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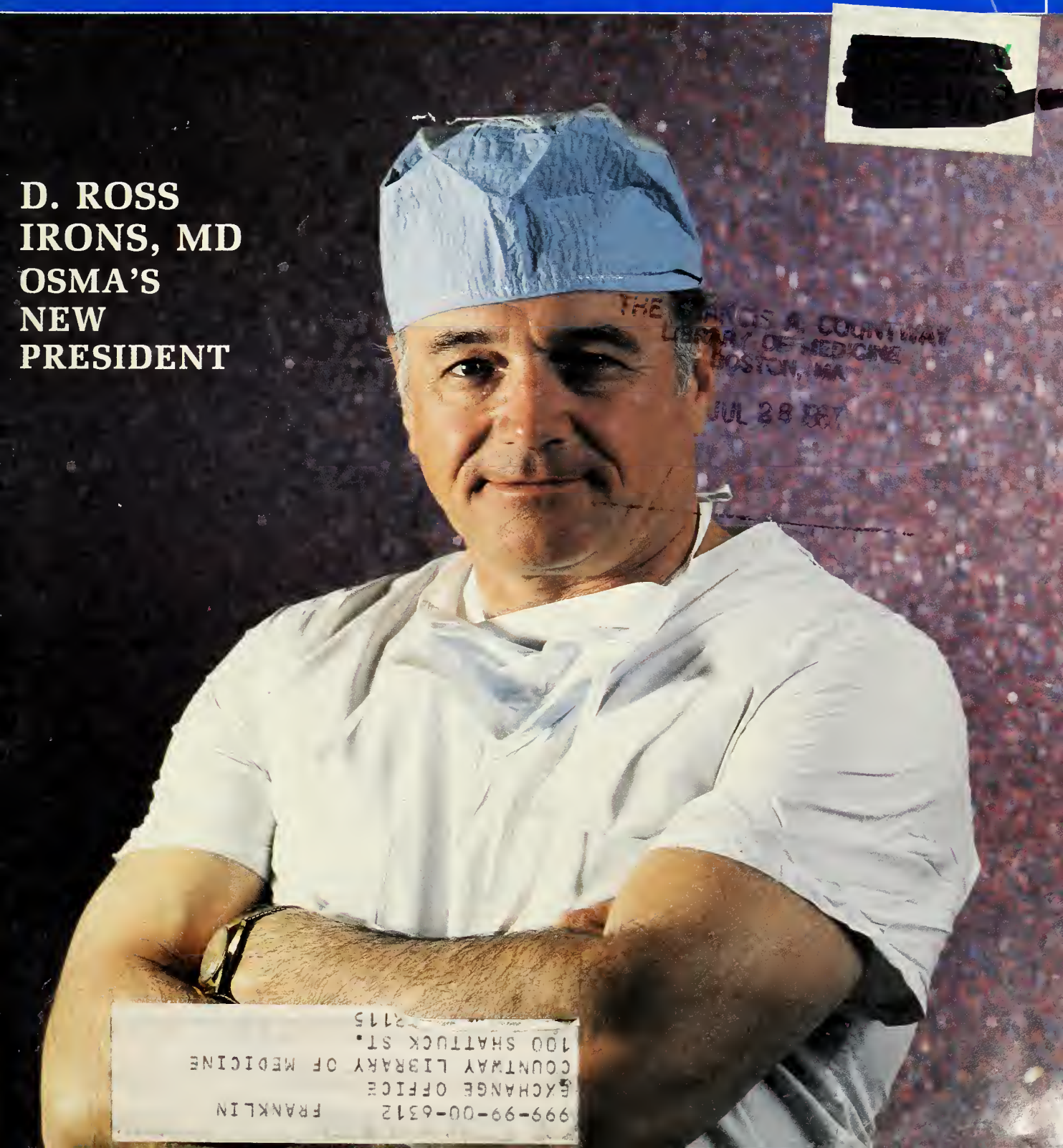

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VOL. 83, NO. 7 JULY, 1987



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FROM THE EDITOR

Wrapping up the 1987 Annual Meeting

In this issue, you will find our wrap-up stories of the 1987 Annual Meeting. The theme for this year's meetings was "The Spirit of Caring" — and, indeed, the "spirit" seemed to be everywhere, as delegates from all over the state convened in Columbus to discuss some of health care's "hottest" issues and how they might be resolved — not just in terms of what would be best for the profession, but, more important (and in keeping with the theme), what would be best for the patient.

The story from the first session of the House, by Associate Editor Deborah Athy, highlights some interesting membership statistics presented to the House by Thomas Morgan, MD, past chairman of OSMA's Membership Committee. Also included are highlights of the speeches given by Nora Feezel, immediate past president of the OSMA Auxiliary and, of course, the speech given by the OSMA's newest past president, John E. Albers, MD.

The story from the final session of the House highlights the discussions, debate and decisions made on many of the resolutions brought before the 1987 House. The official minutes, and action on all the resolutions will be included in our August issue — but for those who want to know immediately how a resolution might have fared, please consult the sidebar "Overview of Actions on Resolutions," which accompanies this article. It will tell you whether the resolution was adopted, defeated, or referred to Council.

Our new editorial assistant, David Sweet, provides a report of the Hospital Medical Staff Section's meeting on "PRO Review Process and Sanctions." Peer review — a perenially controversial subject, anyway, has managed to achieve even more importance of late, as the AMA brought (then later dropped) a suit which pointed up the inequities of the peer review process. You'll find the article timely reading.

This issue also profiles incoming OSMA President D. Ross Irons, MD, the man featured on this month's cover. You'll find him to be a man of strong convictions, decisive action — and one of the best patient advocates in medicine. Be watching for his first "President's Page" which should debut next month.

Also in this issue . . . OSMA Executive Director Herb Gillen shares his collection of "Frazzled Phrases" . . . and Donavin A. Baumgartner, Jr., MD, OSMA's new president-elect, has an interesting pastime which Deborah Athy has highlighted in our "Out of Practice" column . . .

Next month, we'll include news of the upcoming Scientific Meeting scheduled for September. And, of course, we'll be carrying those official minutes from this year's Annual Meeting.

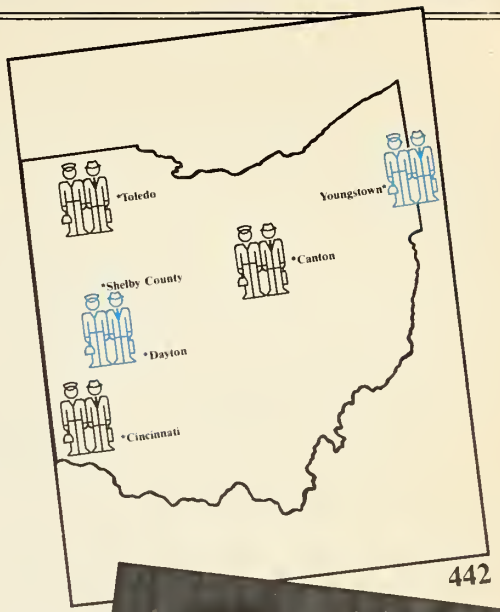
Karen S. Edwards

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USPS 405-200

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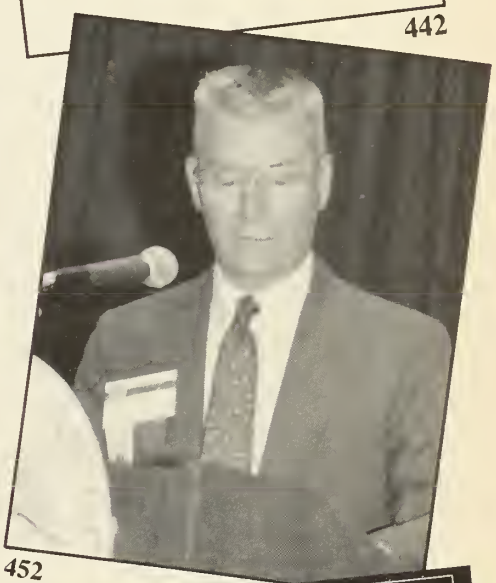
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OUR COVER

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(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

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(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

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"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

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"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

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Published monthly under the direction of The Council for and by members of OHIO Medicine, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1987 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

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A Presidential Profile

D. Ross Irons, MD

By Karen S. Edwards

EDITOR'S NOTE: Next month, Dr. Irons will begin his column in this space. This month, however, we are providing you with a close-up look at the OSMA's newest President.

D. Ross Irons, MD, the new president of the Ohio State Medical Association, makes it clear from the start that he's not out to please everybody during his term of office.

"I'm not a politician," he says.

The statement comes briskly — without apology. It fits his "tough-guy" image as neatly as his presidential slogan — "Take Charge for a Change."

But, then, Dr. Irons has been "taking charge" for a number of years.

A 1960 graduate of the Ohio State University College of Medicine, Dr. Irons traces his roots in organized medicine back to 1977, when he attended the December meeting of the Ohio State Medical Association. Since then, he has served as president of the Huron County Medical Society twice; as delegate and alternate delegate to the OSMA; and as OSMA's 11th District Councilor since 1982. In addition, he has served two terms as chairman of the OSMA's Task Force on "Health Care for the '80s"; as a member of the OSMA Task Force on Professional Liability; on the OSMA's Long Range Planning Committee on membership strength and financial stability; and as one of organized medicine's representatives on the Governor's Commission on Health Care, which ran from April, 1982 until June, 1984.

"I joined organized medicine because I saw a need — a void in the system," he says. He describes that "void" as the numerous third-party entities which intersperse themselves between the patient and the physician. It's an issue which still bothers him, as his remarks before the House of Delegates last May reveal:

"Everyone today is involved in health care planning," he said during the final session. "Insurance companies negotiate health care plans without our input or the patients' . . . hospitals and corporations practice medicine without a license . . ."

"Taking Charge for a Change" is his way of picking up the gauntlet, and urging others in the profession to stand up, too — and be counted.

"Agitated apathy is endemic in the profession," he says. As a result, "we've been battered hither and yon by third-party carriers. It's time we learned to say no to anything that is not in the interest of our patients and our profession."

But saying "no" must be done in a proactive way, he insists.

"Doom and gloom are not my way. I'm not depressed by the complexity of the issues ahead — I'm challenged by them. I think I have an opportunity to be positive in a negative situation."

He recognizes, for example, that the profession must accept self-regulation — that, in the insurance arena, for example, voluntary risk management and fee review at the county level are subjects that doctors can no longer shy away from.

"We have to endure some short-term pain for long-term gain," he says.

But the Bellevue surgeon isn't about to watch medicine endure that short-term pain for long.

"We need to represent our interests in a more assertive way."

He has already outlined several priorities he hopes to accomplish before his year is complete:

1.) Reinstitute the Cancer Committee, and establish a task

continued on page 485

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Let's Not Bury The Annual Physical

By I.C. Sharon, MD

Recent articles in the lay press have questioned the value of annual physical examinations and have often quoted prominent and respected physicians that the periodic checkup is useless. This discourages those patients who may benefit from participating in such practice.

In the atmosphere of a warm doctor-patient relationship, the physical examination can often detect early disease and disturbed function, and can have great value in preventive medicine by serving as a vehicle for imparting information, education and motivation. The primary care physician has the responsibility to stress what the individual himself can do to prevent or retard many of the degenerative diseases and promote creative health and longevity. Improper diet, lack of regular exercise and rest, habits of smoking, drinking and drug abuse, and emotional problems can be discussed and often corrected. The periodic physical is only as fruitful and valuable as the time, effort, and thoughtfulness that goes into it. As the doctor-patient relationship grows, it can become an extended learning experience in promoting health-producing changes.

A physical exam is not for every patient nor for every doctor to perform. The unmotivated patient who seeks only short-term relief and has no insight toward future health benefits will not profit appreciably from a physical. Likewise, an unmotivated doctor with a volume type of practice will not have the patience to perform an adequate physical exam. Even those physicans who believe in annual physicals can be selective and not attempt a yearly physical on every patient.

The first complete physical examination on a new patient is a comprehensive checkup with a thorough history and head-to-toe examination and serves as a baseline for all future visits and later comparisons. It generally includes a blood count, urinalysis, SMA chemistry survey, chest x-ray, electrocardiogram, and any other test which seems indicated. In subsequent annual physicals, the history and bodily examination may suffice. Conditions often discovered in relatively asymptomatic patients include hypertension, diabetes, thyroid problems, and cancer (particularly breast, uterus, rectum, and prostate).

Ordinary office visits cannot replace a physical exam. Their only advantage is economic. The office visit concentrates on symptoms and a presumptive diagnosis, while the physical exam emphasizes the total person and definite diagnosis. Asymptomatic persons do not come for office visits. Time limitations of the office visit do not permit the in-depth interaction between patient and doctor which is so important in a therapeutic relationship. The annual physical re-establishes and enhances the doctor-patient relationship and reinforces what has previously been learned. A bilateral agreement is reached on what conditions are to be treated, future goals are discussed, and the patient takes on increasing responsibility for his own destiny. The annual physical makes future office visits more meaningful, less frequent, and less time consuming, and, although difficult to quantify and

document, is cost effective in the long run. In a physical exam, the doctor employs more ear and less tongue.

While third parties usually will not pay for a routine physical, many of them generally will pay for a physical with symptoms and a supporting diagnosis. Most sophisticated patients who are properly motivated and educated will pay for a physical out of their own pocket when not covered by a third-party payor.

Why has the annual physical been so maligned? Inflationary trends have resulted in an emphasis on a volume type of economic efficiency wherein the doctor spends less time with patients and relies more on laboratory tests and less on a detailed medical history, thus weakening the doctor-patient relationship. A recent tendency to relegate the physical exam to the physician's assistant or nurse practitioner has lessened the importance and value of the in-depth physical exam. The busy doctor can generate more income proportionately from office visits than from time-consuming physicals. Technological advances have encouraged physicians to order more tests and to rely less on the history and physical exam. Furthermore, third-party plans emphasize cost rather than quality of medical care and are reluctant to pay for more costly physicals.

While it is difficult to prove statistically beneficial results of annual physical examinations in terms of longevity, morbidity and long-term cost, it has been my experience in almost case after case that patients tend to adopt a healthier lifestyle following annual physicals. I have observed that these patients generally pay attention to good nutrition, tend to get regular exercise, and attempt to deal with their emotional hangups and unhealthy habits. **OSMA**

I.C. Sharon, MD, Cincinnati, is Clinical Professor of Medicine, Emeritus, University of Cincinnati College of Medicine.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of OHIO Medicine *or the Ohio State Medical Association.*
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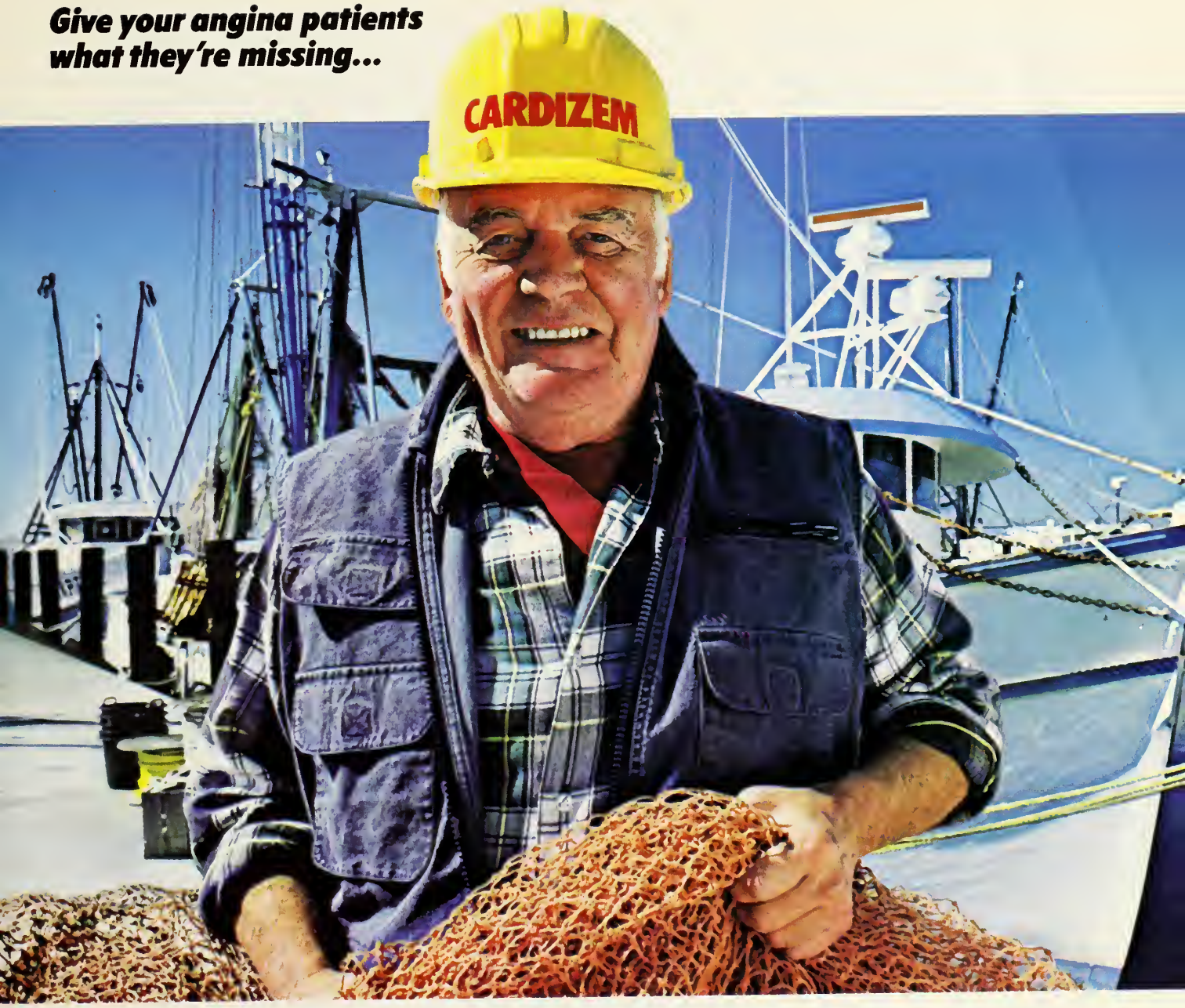
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WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/posthatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 7/86*

See complete Professional Use Information before prescribing.

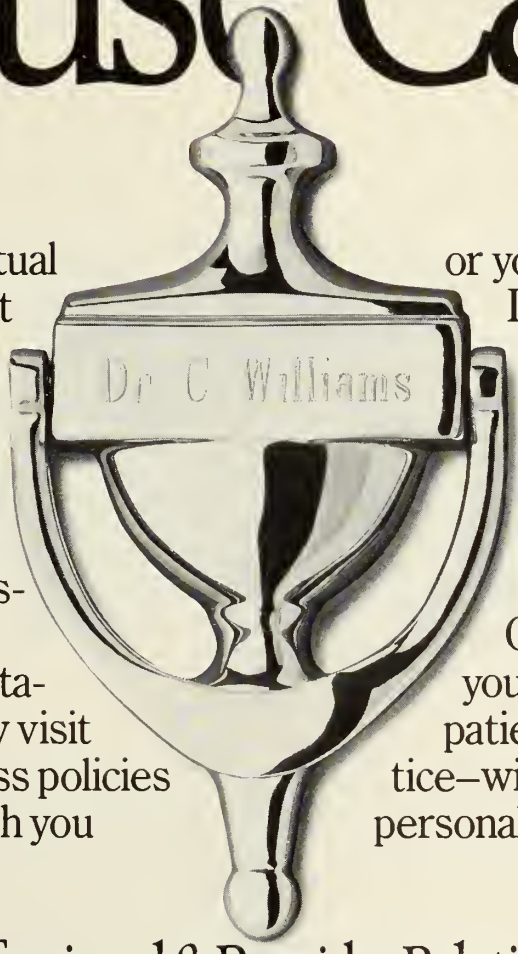
References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al. Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347.* ***2.*** *Shapiro W. Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984; 24(Dec):150-159.* ***3.*** *Johnston DL, Lesaway R, Humen DP, et al. Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

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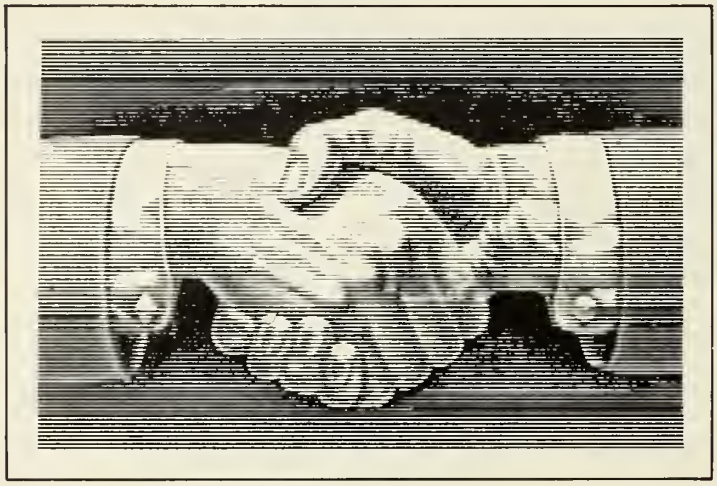
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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Heterosexual AIDS transmission

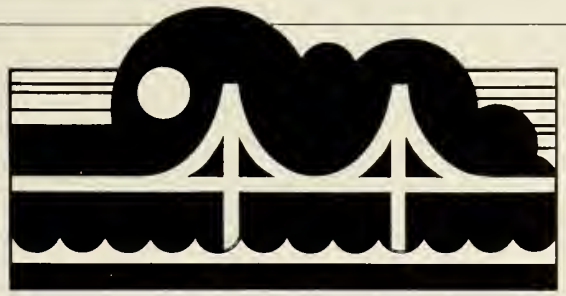
The number of U.S. women who have acquired AIDS through heterosexual contact has more than doubled since 1982, according to a Centers for Disease Control (CDC) study published in the *Journal of the American Medical Association.*

As of late 1986, the CDC reported 1,819 cases of AIDS in women — 52% of these women were intravenous drug users, and 21% contracted AIDS through sexual contact with infected men.

The study points out that while the number of women in the IV drug use category has decreased since 1982, the proportion of women infected by sexual contact has jumped from 12% to 26% between 1982-86.

"Heterosexual contact is the only transmission category where women with AIDS outnumber men with AIDS," says the CDC study. "In the United States, at the present time, a heterosexual woman is at greater risk for acquiring AIDS through sexual intercourse than is a heterosexual man."

This increase in heterosexual transmission carries with it another major concern: 80% of these women are of child-bearing age, and the majority of childhood AIDS cases results from perinatal transmission, the study reports.



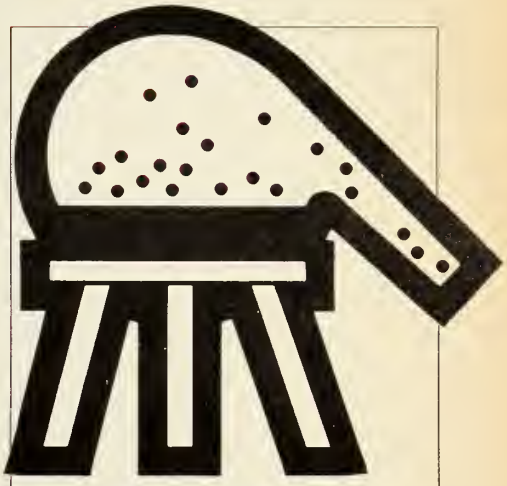
Caution in San Francisco

Homosexual, bisexual and heterosexual men in San Francisco are reducing their number of sexual encounters in recent years, probably due to the threat of AIDS, according to data reported in the *Journal of the American Medical Association.*

Colleagues from the University of California in Berkeley described findings of the San Francisco Men's Health Study of human immunodeficiency virus (HIV) infection and AIDS in 1,000 single men age 25 to 54.

The study found that the numbers of homosexual and bisexual men reporting 10 or more sex partners fell by 60% between 1984-86, "resulting in a substantial decline in the HIV seroconversion rate."

And while single heterosexual men generally reported fewer sexual encounters than other men, their number of female sex partners also declined in this same period, the study claimed.



AZT: Supply and demand

Not only is azidothymidine (AZT) only available to certain adults infected with human immunodeficiency virus, it may be inaccessible to others because of its price, according to *American Medical News.*

The Food and Drug Administration has cleared Burroughs-Wellcome Co. to market AZT — brand name *Retrovir* — to prolong survival and reduce the number of AIDS-related opportunistic infections in people with AIDS or ARC.

According to *AM News,* the drug will cost patients about $10,000 a year, and many will find their health insurance coverage does not cover medication taken out of the hospital. While some carriers do offer outpatient pharmacy benefits, many of the largest insurers do not, the article claimed.

However, most of the AIDS patients on Medicaid *will* be able to receive the drug at little or no cost, and several insurers say they will consider ways to lessen the burden on those patients who are not covered for outpatient pharmaceutical benefits.

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OHIO MEDI-SCENE

OSMA updates . . . books for your reference shelf . . . insertion of catheters . . . Medicaid tips . . . the OMPAC Luncheon . . . mini-internships part II . . .

OSMA updates keep members informed

News at your fingertips — Do you have a minute to spare between rounds? A little time before your first patient is scheduled? If so, dial the OSMA Toll-free Hotline — at 1-800-346-OSMA, for a pre-recorded message highlighting the latest and greatest in Ohio medical happenings. Legislative updates, including statehouse scoops on professional liability and other issues affecting medicine; around the state medical breakthroughs; don't-miss seminars and meetings, and CME information are just several of the subjects featured.

The Hotline, initiated by the OSMA Department of Communications and Physician Marketing, is updated several times a week to ensure that the news you receive is hot off the press. Available seven days a week, 24 hours a day, the hotline is accessible, as well as to-the-point, giving you the important facts in a clear and concise manner.

The OSMA has always made it a priority to keep its members well-informed on the issues — with *OHIO Medicine,* and *OSMAgram,* Ombudsman Services, and the *Legislative Bulletin,* among other resources. The Hotline is yet another way of keeping the lines of communication and information open . . . and it's just one more benefit of your membership.

As you know, many pertinent and newsworthy events happen every day in medicine — events which affect the OSMA, and, in turn, affect all physicians in every corner of the state. In order to keep informed and up-to-date on these issues, dial toll-free, 1-800-346-OSMA, for all the news — as close as your fingertips.

A wealth of assistance: the County Medical Society Handbook . . . Have you ever had a question about Medicare reimbursement, contracts, or how to deal with the media — but weren't sure who to call? Fret no more.

Through an industrious and thorough inventory of the OSMA — its services, staff, member benefits, history, policies, resolutions, etc. — everything you've ever wanted to know about your state organization has been accumulated, categorized and organized into a handy reference guide.

These handbooks were distributed to all County Medical Society and Specialty Society presidents and executive directors by Past-President Herman I. Abromowitz, MD, at the 1987 OSMA Annual Meeting. The handbooks actually benefit *every OSMA member,* because as each county and specialty society becomes more informed, the OSMA as a whole becomes more informed and more united.

The handbook is just one example of the OSMA's long-standing and continuing efforts to strengthen the relationship between component and affiliated county societies and the OSMA. Without these societies, the OSMA would be hard-pressed to function at optimum capacity. Each county medical association — no matter how small — is an intricate and essential part of the OSMA.

The handbooks were suggested by the OSMA Communications Committee, chaired by William J. Dorner, Jr., MD, as a way to keep county medical societies and specialty societies better informed and to answer the many requests for information that the OSMA receives. The OSMA Communications and Physician Marketing Department then took this idea from the drawing board to its final stages, with help along

OHIO MEDI-SCENE

OSMA updates . . . *continued*

the way from other OSMA departments.

Some of the sections in the handbook include: A who-to-call list of OSMA staff, descriptions of OSMA-sponsored public relations programs available for use by other societies and a complete list of OSMA policies. In short, there's a little about just about everything!

Last but not least: The 1987 Clinical Update and Exposition . . . All of the discussions, seminars and debates associated with the 1987 Annual Meeting have not yet come to a close. Mark your calendars now — the Scientific portion of this year's Annual Meeting is just around the corner, September 18-20, and will be held at the Hyatt Regency in Columbus.

By the action of OSMA Council, the Clinical and Scientific section has been split from the House of Delegates section, in order to give both meetings the individual attention and time they merit.

The Clinical update section focuses on the very core of the medical profession — that is, the practice of medicine itself. This two-and-a-half day program kicks off with a program no Ohio physician should miss, "AIDS: What the Practicing Physician Should Know," which is bound to offer a multitude of valuable insights into what has been referred to as the most serious health problem of the 20th century.

Other programs include: Vascular Lab and the Primary Practice Physician; Common Office Emergencies; Early Management of Stroke; Examination of the Sexually Abused; Diagnosis and Management of Angina; as well as many others. The AMA Practice Management Department will also conduct a practice management workshop on Alternative Delivery and Financing Systems.

Keep in mind that these programs will earn you Continuing Medical Education credits, so your benefits are twofold: not only will you be offered an array of medical programs, seminars and exhibits, but you'll also be meeting your CME requirements at the same time.

Keep an eye out for registration materials which will be included in future issues of the *OSMAgram,* as well as *OHIO Medicine.* — *Deborah Athy*



For your reference shelf

Two publications, recently released by two different Ohio health care groups are worth your attention — and maybe a place in your office or waiting area as well.

The first of these, "The 1987 Greater Cincinnati Hospital Council Directory" is a handy reference guide for those in the tri-state area. Compiled like a catalogue, the directory lists the types of services provided by area hospitals, as well as listing administrative staffs and the number of beds and bassinets operated by each institution. The guide is especially useful for those physicians who may be seeking help for patients with a particular need — be it sleeping disorders, or the special medical problems associated with aging. The guide will tell them where to find clinics, programs and so on, which will offer help in both these areas and more. Published by the Greater

Cincinnati Hospital Council, the cost of the directory is $7.50 plus postage. To order a copy — or for more information — write the Hospital Council, 1811 Losantiville Ave., Suite 450, Cincinnati, Ohio 45237 or call (513) 531-0200.

The second publication — actually a brochure entitled "Sports and Your Child" — has been published by the Ohio Chapter of the American Academy of Pediatrics and was prepared by its committee on Youth and Sports Medicine.

According to Leonard J. Janchar, MD, a Marion pediatrician and a member of that committee: "We felt, from personal experience, that there was a need in the community for the type of information presented in the brochure."

The need stems, in part, from the proliferation of youth sports and the number of youngsters participating in them. With the array of choices before them, parents — even children — become confused as to *which* sport the child might best be suited for. And, of course, there are questions about the coach and his or her ability to supervise the activity at hand.

"Coaches are often not adequately prepared to deal with children," says Dr. Janchar — either in teaching the skill because his or her own skills have become rusty; or in dealing with the emotional and psychological differences of children.

The brochure, however, features some pointed questions parents should ask coaches of youth sports programs.

"Parents should meet with coaches the same way they would meet with a teacher to discuss their child's abilities in the classroom," says Dr. Janchar.

But coaches are not the only ones who need to answer a few questions. Parents, too, should be asking themselves what they are expecting from their child's participation.

Parental pressure on a youngster to excel is still the source of numerous emotional problems for children, and the brochure takes care to emphasize that competition should be kept in perspective.

Parents, too, should take care that their child does not become overprogrammed with too many activities — an issue the brochure raises by discussing commitment.

"Parents are in a hurry to have their children grow up," says Dr. Janchar, explaining that children are sometimes pushed into adopting too many outside interests, and, as a result, develop neither the skill nor the confidence level necessary to perform any of them well.

On the other hand, some children develop problems when they specialize — "a problem we usually see in association with gymnastics," explains Dr. Janchar. For example, we have seen overuse sports injury in 10-year-olds who practice gymnastics three and four hours a day."

What children need, he continues, is a well-rounded sports experience — including, when possible, training and encouragement in sports, like swimming, that can be pursued on an individual basis throughout life.

In essence, then, the brochure is, an ice-breaker . . . a way to open up conversation between parent and physician about the sports program in which a child may be involved.

"I try to do this regularly with the child. I'll ask 'what are you doing this summer?' 'what do you do in your spare time?', 'do you have any hobbies?' " If the child participates regularly in a sports program, he'll ask the child if he or she likes the sport . . . an important consideration, he adds, if the participation is to be worthwhile.

That's the kind of interaction Dr. Janchar and others on the Youth and Sports Medicine Committee hope will be stimulated by the brochure.

Parental pressure on a youngster to excel is still the source of numerous emotional problems for children.

"Pediatricians (and, one might add, others on the front-line of medicine) need to get into counseling parents in this area," Dr. Janchar says.

The brochure is available at $10 per hundred copies from the Ohio Chapter, American Academy of Pediatrics, 920 Macgregor Ave., Worthington, Ohio 43085. For more information, call (614) 846-6258. — *Karen S. Edwards*

Insertion of arterial and central venous catheters

In some instances, nurses in Ohio have been asked to insert arterial and central venous catheters in patients. This procedure may result in complications that are life threatening to the patient and may require physician intervention. It is the recommendation of the Ohio State Medical Association-Ohio Nurses Association-Ohio Osteopathetic Association Liaison Committee that this procedure be performed only by physicians appropriately trained in the procedure. It is not a nursing procedure. (This statement does not apply to certified nurse anesthetists who are inserting central venous and arterial lines as part of practice related to the administration of anesthesia.)
— *Submitted by Claire Wolfe, MD, OSMA-ONA-OOA Liaison Committee*

OHIO MEDI-SCENE

Medicaid tips

The Ohio Department of Human Services makes changes in the drug formulary quarterly. Presently, the scheduled changes for the updates are February 1, May 1, August 1 and November 1.

Most of the additions and all of the deletions are based on recommendations presented by the Pharmacy and Therapeutics Committee. The committee is comprised of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Waltenbaugh, RN; and Robert P. Reid, RPh, Chairman.

At the February P & T Committee meeting, the following issues were resolved that will impact on the **August 1, 1987** update:

- **Establish a MAC for:** Sulfamethoxazole/TMP 80/400, 160/800 Tabs; Bulk Laxative; Papaverine 150mg, 300mg; Ephedrine Sulfate 25mg; Guaifenesin DAC Syrup; Lactated Ringers Soln; Metoclopramide 10mg; Nystatin Topical Cream, Ointment.
- **Add the generics of:** Dymelor (Acetohexamide); Keflex (Cephalexin); Velosef Susp (Cephradine); Deconamine SR (Chlorphen/Pseudo 8mg/120mg); Combipres (Clonidine/Chlorthalidone); Cafergot Supp (Ergotamine/Caffeine); Norgesic and Norgesic Forte (Orphenadrine/ASA/Caffeine); Dilantin 100mg (Phenytoin Ext Release); Karidium (Sodium Fluoride Drops); Loniten 10mg (Minoxidil), Procan SR 1000mg (Procainamide)
- **Change the NDC numbers of:** Congess JR; Desquam-X Wash 5 PC; Folvite Inj., Intal Spinhaler; Lorelco; Parhist, Poly Vi Flor FE 0.25 mg; Ru-Tuss 5/2.
- **Delete as no longer manufactured:** Allergine; AVC Dienestrol; Bellergal; Butibel-Zyme; Crystodigin 0.2mg; Econochlor Soln; Oxalid; Phenergan CPD; Povan; Predulose; Prioderm; Sulfacel; Sparine Syrup; Urimed.
- **Delete as no longer manufactured some package sizes only of:** Adeflor 0.5mg, 1mg; Crystodigin 0.05mg, 0.15mg; Demulen 1/35, 1/50; Halotestin 5mg; Ismelin 10mg, 25mg; Ovulen 20,21,28; Phazyme PB; Serpasil 0.1mg; Serpasil Esidrix #1, #2.
- **Delete due to error re-entry:** Micatin 2PC
- **Delete due to error entry:** Stadol, one NDC
- **Delete due to Duplicity:** Ampicillin PRB Susp; Some NDCs of Metaprel; Xylocaine Ointment.
- **Delete due to lack of necessity because of generic entries:** Beta-Val; Genfiber; Natural Veg Lax; Reguloid; Uni-Laxative; Vegetable Laxative; Erythromycin Succinate Lederle; Bulk Lax NDC 11822.
- **Change billing quantities and assign new numbers for:** Aluminum Hydroxide Gel-Susp; Aluminum Hydrox-Mag Carb; Aluminum-Mag Hydrox; Aluminum-Mag Hydrox W/Simeth; Hydroxymag Aluminate; Bulk Laxative. Despite the conversion from bottles or containers to GM or ML, these products should be dispensed in full 120Z or 160Z for the antacids or full 140Z or 210Z for the laxatives.
- **Add as new entries:** Atrovent INH; Brexin LA; Cardizem 90mg, 120mg; Corgard 20mg; Creon; Cytosar U Inj; Erythromycin Caps Abbott; Estraderm 0.05mg, 1mg; Glutose; Gynex; Hypotears Soln; K-Norm; Konsyl; Marblen Tab, Susp; Morphine Sulfate 10mg; Nitroglyn 2.5mg, 6.5mg, 9mg; Oxazepan Tabs, 15mg; Persantine 50mg 1000's, 75mg 500's; Prolixin 5mg 100's; Proventil and Ventolin Soln For INH; Psorcon Ointment; Retrovir 100mg; Roferon-A new size; Roxicet Oral Soln; Symadine 100mg; Vaseretic; Zostrix; Potassium SR 600mg and 750mg.
- It should be noted that only Bolar and Sidmak were manufacturing generic bioequivalents to Dilantin 100mg Kapseals as of February 1987. There is a possibility that Gynex, although listed as an addition, may not be available in August 1987.

To keep you informed, your OSMA representative to the P & T Committee will be providing information as it develops.

— *Janet Bixel, MD*

Physician involvement needed for political success

Physicians must become involved in the political process, if they want to have any input in how medicine will be practiced in the future, says Vernal G. Riffe, Jr., Speaker of the Ohio House of Representatives.

"Whether you like it or not, it's our system today that people *have* to be involved in politics," said Speaker Riffe, who has served as Speaker of the Ohio House for nearly 12 years — longer than any speaker in Ohio's 184-year history.

"In the last session of the legislature, we had over 120 pieces of legislation introduced that affected physicians in some way or form," he said. Speaker Riffe, who was the featured speaker at the Ohio Medical Political Action Committee (OMPAC) luncheon held during the 1987 OSMA meeting, focused on the Ohio political scene and on the present liability crisis.

He predicted that health care will be an even bigger issue in the years to come. Speaker Riffe, who is also entertaining gubernatorial aspirations for 1990, plans to make certain that health care gets the attention it deserves.

Although he admitted that our political system has some flaws, he was quick to defend it. "People have their own philosophies about how we should solve problems — this is what makes our system so great," he said. He believes that physicians are — as a whole — respected more than most other professionals, and urges them to use this credibility to speak out and be heard by the political system. "I listen to physicians about health care, but I listen to them about other issues as well," he said. Speaker Riffe commended the OMPAC legislation staff for helping him evaluate important pieces of health care related legislation. "They point out things to me that need some work, things in a bill that are bad — they make me take a second look," he said.



Vernal G. Riffe, Jr., Speaker of the Ohio House, addresses those who attended this year's OMPAC Luncheon.

Concerning the liability crisis, Speaker Riffe said any bill that would come out of the House of Representatives would be "fair, one that had undergone much consideration and debate and one that did its best to stay within the constitution." He said, however, that no matter what bill is passed by the legislature, new laws won't solve a problem immediately.

Speaker Riffe understands the liability crisis well, as he is a former insurance agent himself. "Rates have gone sky high; some people can't afford to buy it," he said. "That's why I took the initiative to do something about it last summer."

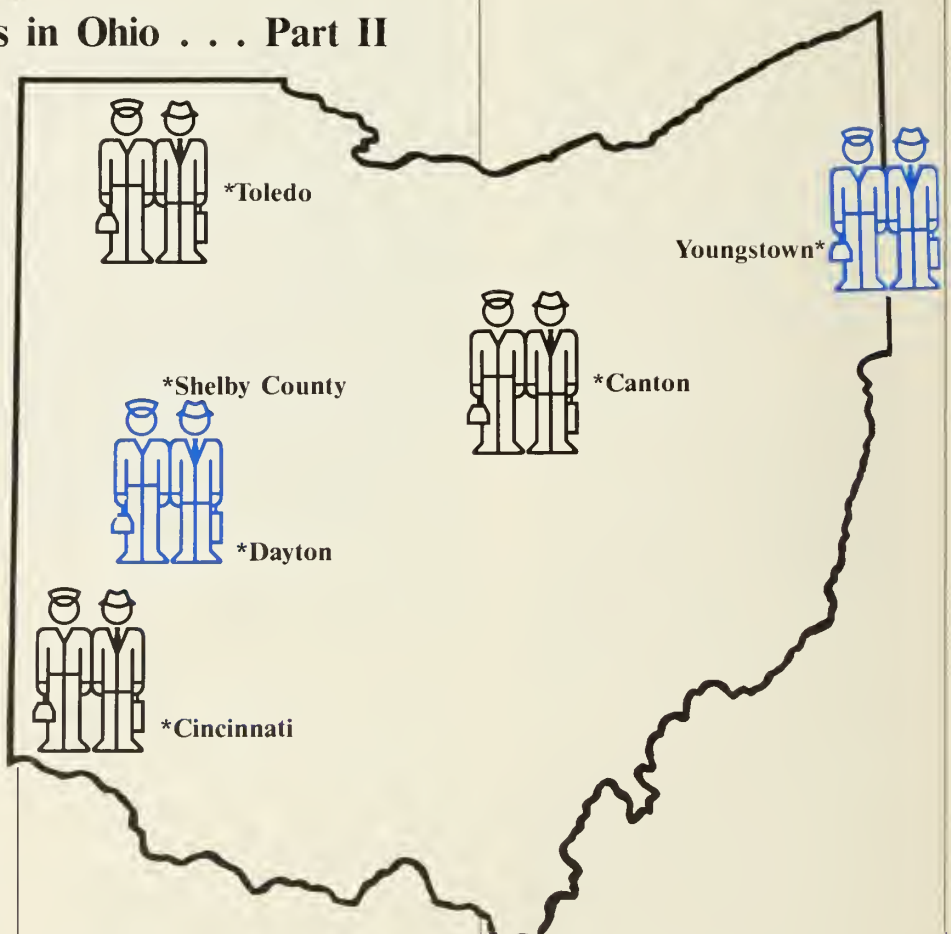
As for tort reform, Speaker Riffe said there is a lot of work going into the issue at the legislative level. "I'll do everything I can to make it a good, strong bill — to help solve the problems of the medical profession," he said.

Speaker Riffe told physicians that he — and Ohio legislators — need the help of Ohio doctors, and urged them to contribute to the political process and make their views known. "You have more influence locally than you may think you might have," he said.

He concluded by challenging physicians, no matter how busy they may be, to make their voices heard. "You've got to be in the ballgame; you can't sit back and let somebody else do it." — *David Sweet*

OHIO MEDI-SCENE

Mini-internship programs in Ohio . . . Part II



Shortly after the April issue of *OHIO Medicine* was released, we received notice that Toledo, Dayton, Cincinnati and Canton aren't the *only* cities in the state where mini-internship programs exist. While we had no intention of overlooking anyone in the story "Mini-internship programs in Ohio" which ran in our April "Ohio Medi-scene" section — the fact remains that two counties *were* overlooked.

Therefore, we are mentioning them now — both for your information, and to make amends.

"Stark County is not the new kid on the block — Mahoning County is," wrote Mahoning County Medical Society Executive Director Robert B. Blake in a letter calling attention to our omission.

The Mahoning County program has already held two sessions — the last one in January, with five interns; and the next is slated for sometime in the near future, when six interns will have an opportunity to observe health care "up-close" with their physician-mentors.

Also omitted in that issue was Shelby County's Internship program — kindly brought to our attention by Second District Councilor William J. Marshall, MD. The program there is administered by medical society President Ed Link, MD, and in a conversation with him, we learned that the Shelby County program is two years old, and presently involves only members of the area hospital's board of trustees.

"The first session, all 12 board of trustee members came through," he says. Other sessions will be held as new board members join. Typically, the interns spend one day at the hospital and another day in the doctor's office. Dr. Link was reluctant to say whether or not other professions will be asked to participate in the program. "It's harder in a small town," he says. "The patients are more at ease if they know the person coming through the program is affiliated with the hospital" — but, so far, the possibility of others participating in the program has not been ruled out. "It's still up in the air," he comments.

While we're also aware of other county medical societies which are in the process of forming mini-internship programs — we'll save them for a later update. And, again, our apologies to those we missed. — *Karen S. Edwards*

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The First Session of the House

By Deborah Athy

In mid-May under what William A. Millhon, MD, president of the Columbus Academy of Medicine, described in his opening remarks as the "ever-changing skyline of Columbus," delegates and alternate delegates to the Ohio State Medical Association met to consider a diverse collection of resolutions and to induct D. Ross Irons, MD, as OSMA president for the coming year.

After the minutes of the 1986 House of Delegates meeting were unanimously approved, AMA Board of Trustees member Ray W. Gifford, Jr., MD, of Cleveland, stepped forward to address the House on some current AMA activities.

Fairer court procedures for PRO sanctions, a newly-created Foreign Medical Graduate (FMG) section, and the Adolescent Health Initiative are some examples of how the AMA continues to work to protect both physicians and the public, said Dr. Gifford.

He also reported a 5.5% increase in dues-paying AMA members in the first months of 1987, as compared to the beginning of 1986 — an increase which he said gives medicine a stronger voice on the national front.

Dr. Gifford then called attention to a Massachusetts law, linking licensure to the acceptance of mandatory assignment for Medicare. Although this law was appealed by the AMA, it was upheld in the Massachusetts court, and is scheduled to go before the Supreme Court in the near future. The outcome will have repercussions in every state, he predicted. "It is a cloud on the horizon we must watch very closely."

After the introduction of past-presidents of the OSMA and other honored guests, Thomas W. Morgan, MD, of Gallipolis, chairman of the OSMA's Membership Outreach Program, addressed the House regarding the importance of membership — which he referred to as "the lifeblood of the association."

"At the risk of sounding like a broken record, membership is still the name of the game," he stressed.

To ensure that a strong state membership is continued, OSMA Council recently created a special membership department at the OSMA's home office to deal exclusively with membership efforts. Katherine Wisse, OSMA associate executive director and new director of membership development, will devote her energies full time to this endeavor, he said.

While OSMA has increased its membership from 19,191 in 1985 to 19,877 in 1986, Dr. Morgan attributed the growth to the steady influx of student and resident members and not to an increase in *dues-paying members.* In fact, there is still a 4,000-5,000 non-member nucleus in the state which must be cracked, he pointed out.

That's why the Physician Outreach Program — is of vital importance, he said. In 1986, 128 members joined as a direct result of this program.

Individual physicians, who were honored for their membership recruitment accomplishments, included: Claire V. Wolfe, MD,



Above: Members of the Twelfth District Delegation strike up conversation with nearby colleagues as they wait for the House to begin. Below: The 1987 OSMA House of Delegates has been called to order.



"After hearing all the excuses for not joining (the OSMA), I have yet to hear a really good one."



Thomas Morgan, MD, presents the report of the Membership Committee during the House's opening session.

Columbus, for recruiting 71 new members; Donavin A. Baumgartner, Jr., MD, OSMA president-elect, Cleveland, 19 members; Joseph L. Kloss, MD, Akron, 11; and Jack L. Summers, MD, Akron, 4.

Dr. Morgan also applauded Paulding, Perry, Hancock, Morgan, Carroll, Knox, and Shelby Counties for meeting the ideal goal of 100% physician membership.

In addition, for the 11th year in a row, OSMA membership in the AMA has continued to increase, Dr. Morgan reported, although the proportion of young physician members continues to decline. "If this trend continues to the year 2000, the AMA will no longer represent the majority of Ohio physicians," he emphasized.

Still, Ohio has the fifth largest state representation in the AMA House of Delegates, "which translates into a louder, more informed voice on the national scene," he said — adding that since 1980, the number of OSMA delegates to the AMA has increased from 10 to 19.

But Dr. Morgan focused on the fact that membership among women, foreign medical students and young physician graduates remains lower than desired, and thus will be areas of membership focus in the coming year.

In closing remarks, Dr. Morgan, who is resigning from his position as membership chairman after seven years, described the job as both a rewarding and frustrating experience. "After hearing all the excuses for not joining (the OSMA) I have yet to hear a really good one."

"The power that comes from speaking with a united voice gives medicine an advantage we cannot afford to lose."

Following Dr. Morgan, the 1986-87 Auxiliary President, Nora Feezel, gave a roundup of the auxiliary's activities and efforts over the year. "CATS — or Concerned Auxilians Target Safety — was our theme, and health projects our main focus," she told the House.

Together with the American Cancer Society, Ohio Division, and the Ohio Dental Auxiliary, the auxilians worked to extinguish the use of smokeless tobacco, by introducing a resolution into the AMA's Auxiliary House of Delegates and by providing education on this issue to some 250,000 Ohioans, including 30,000 school age children.

The OSMA Auxiliary has also been actively pushing for a mandatory motorcycle helmet law for all ages, as well as supporting AMA-ERF through the Christmas Sharing Card, which has been successful nationwide.

"In these days of laws and more laws, the continued cooperation between the OSMA and the Auxiliary on the legislative front gives medicine a loud voice in Ohio and the nation. This important liaison must be continued and allowed to flourish," Mrs. Feezel emphasized. "Together we are strong."

Wrapping up her remarks, she acknowledged the passing of another year. "I think it was a successful year, and I am proud to have served as the president of such a vibrant and active auxiliary."

Next on the agenda, AMA-ERF contributions were distributed to each of Ohio's allopathic medical schools including Ohio State University, University of Cincinnati, Case Western Reserve University, Medical College of Ohio, Wright State University, and the Northeastern Ohio University College of Medicine. In all, $97,569.68 was distributed.

Janet Bixel, MD, an Ohio Medicaid Drug Formulary Committee member, approached the podium to share pertinent formulary information with the House. She reported that the new AIDS drug AZT (azidothymidine) will be included on the drug formulary in August 1987, although physicians can acquire the drug by automatic prior authorization until that time.

In addition, she said cough and cold medications included on the drug formulary have been revised (see May 1987 *OHIO Medicine* for a complete listing), and she emphasized the importance of writing "DAW" on prescription forms to ensure that a patient receives a brand name drug instead of its generic substitute.

Next, the lights were dimmed and the House of Delegates was treated to a unique audiovisual presentation highlighting OSMA member benefits, services, activities and accomplishments. The big-screen slide show concept was suggested by Dr. Albers, and the Department of Communications and Physician Marketing, under the direction of Carol Mullinax, got the project rolling.

The slide show exhibit displayed — among other things — the diversity of the OSMA membership — the number of different specialties, county societies and corners of the state represented. But the slide show was quick to point out that "the diversity of the OSMA should never hide the fundamental purpose that unites us — to protect the rights of physicians and their patients."

The theme of the 1987 Annual Meeting — "The Spirit of Caring" — was evident in every frame, as physicians from around the state were shown in operating rooms, meetings, doctors' offices, committees, House of Delegates sessions and in classrooms.

"The power that comes from speaking with a united voice gives medicine an advantage we cannot afford to lose," the slide show continued — a concept that was echoed again and again during the course of the evening.

The slide show took a look, too, *behind* the medical scenes — at the legislative front, for example, where issues such as professional liability, mandatory Medicare assignment and the scope of practices of allied practitioners are being hammered out — to show how the OSMA is working to protect medicine's interests.

Other highlighted areas included the OSMA legal department, featuring the new contract analysis service; the OSMA Ombudsman service; OMPAC; and the association's involvement with agencies and organizations which impact medicine, such as the Departments of Health and Human Services and the Medical Board.

In addition, the OSMA's longstanding commitment to communications with its members and with the public was also featured in the show. The OSMA

"To the House of Delegates falls the difficult task of . . . setting the course for the future."



Above: Ray Gifford, MD, presents a report of AMA activities and goals.

Below: Nora Feezel, 1986-87 OSMA Auxiliary President, informs the House about Auxiliary actions during the past year.



has always strived to maintain open channels of communication with member physicians — through *OHIO Medicine,* the *OSMAgram, the Legislative Bulletin,* as well as other services. But the association has taken its efforts even further with the development of a County Society Handbook to strengthen the link between itself and its component societies. The installation of a new toll-free hotline (1-800-346-OSMA) also helps keep members up-to-date on important medical happenings.

"Successful medical policy can only be formulated by the thoughtful give-and-take of ideas. It's your association," the slide show emphasized, "individual physicians are encouraged to participate at all levels."

The OSMA has also pledged a commitment to improve communications with the public by developing a new series of educational brochures about medical topics such as Medicare and professional liability, in addition to producing news releases and newspaper supplements.

The slide show also offered a challenge to those in the audience: "To the House of Delegates, as elected representatives of physicians throughout the state, falls the difficult task of examining the changing medical environment and setting the course for the future."

In a final note, which again addressed the "spirit of caring" concept, the slide show commentary concluded: "Whatever the future holds, the spirit of caring is at the heart of the medical profession. This is one commitment that all physicians can agree upon."

Following the slide show, President John E. Albers, MD, approached the podium.

He began his Presidential Address by describing the past year as "a pleasure and an enlightenment." He, too, had many things to say about OSMA accomplishments, as well as the challenges that would face it in the future.

For example, by the late 20th century, he pointed out health care costs will comprise about 12% of the Gross National Product, or approximately $700 billion. "Does the National Health Policy developed under the leadership of the AMA supply the direction in dealing with these costs?" he asked — then answered that the AMA is indeed leading the way in "meeting the problems of the past and present and the challenges of the future."

In addition to these *economic* challenges, medicine will also be faced with such problems as the rapidly growing elderly population, contract medicine, tighter government control and the rationing of health care. "All of which may result in a multi-tiered medical care delivery system with regional medical care centers, probably controlled and administered through government," he said.

Ethical issues — including genetic engineering, surrogate motherhood, right-to-life and in vitro fertilization — will also be brought into focus. "As technology improves, more ethical decision-making will be required," and organized medicine must take the lead in setting appropriate standards and guidelines, he stressed.

The availability of health care — for the indigent and the elderly,

"We cannot let ourselves be fragmented by the corporization or specialization of medicine."

for example — is yet another issue which organized medicine will have to come to grips with, and the souls of many will be tried.

"The AIDS epidemic and other catastrophic diseases will further encroach on the availability of funds," but "we as physicians should never sacrifice quality of care for our patients because of economic necessity."

The purpose of the OSMA is and always has been two-fold, to work for the education and representation of physicians and to advance the health care of the public. "We have a noble profession — a time-honored profession — a profession that cares about people," he continued.

But in order to keep the profession of medicine noble, strong and effective, physicians must work together and present a united front. "We cannot let ourselves be fragmented by the corporization or specialization of medicine." And, he added, the OSMA must represent all physicians — whether in private practice, HMOs, IPAs, etc.

After all, "an organization is no stronger than its membership," he said. "We need everyone in the organization to be recruiting members."

Finally, he pointed out that organized medicine will be challenged and challenged mightily in the 1990s. It will continue to be attacked from within and without. Some soothsayers may be predicting the end of organized medicine as we know it, he said — but then added "I don't believe this for a minute . . ."

"All levels of organized medicine are working to resolve present challenges, and a strong leadership is already in place to continue these efforts into the future," he said. "Ross Irons will need your support. I am sure you will give it to him."



John E. Albers, MD, gives his Presidential Address before members and delegates at the opening session of the House.

Dr. Albers expressed concern, however, that the public's admiration for the medical profession appears to be slipping, and that fewer and fewer young people are choosing to pursue medical careers. He suggested that situations such as an increased lack of freedom and independence in practicing medicine, increased government regulation, third-party carrier concerns, and the divisiveness of proliferating HMOs, PPOs and IPAs contribute to these situations.

In addition, he suggested that organized medicine should examine the structure of medical education itself as a contributing factor: Is medical school too long, too expensive and too specialized?

While there are still many questions to be answered, Dr. Albers maintained that "the future of the OSMA is bright and will, under our leaders, meet the challenges of the 1990s." **OSMA**

Deborah Athy is Associate Editor of **OHIO Medicine.**

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The Final Session

By Karen S. Edwards

A total of 50 resolutions were presented to the House of Delegates for consideration during this year's OSMA Annual Meeting, held May 15-17 in Columbus.

Topics ranged from mandatory Medicare assignment and mail-order prescriptions to parking for the temporarily handicapped and the ethics of hospital advertising.

Discussion on all resolutions was heard during reference committee hearings Saturday morning — and by Sunday afternoon, when the House of Delegates convened for its final session, 52 proposals were presented for formal vote. Of those, 21 were passed; 5 were defeated; 14 were placed on the consent calendar (6 of which were removed for discussion and action); and 12 were referred to Council.

Although Reference Committee One heard some testimony Saturday on those resolutions under its consideration, more debate ensued on the House floor on Sunday.

Discussion of Resolution 01-87, calling for Medical Specialty Society Representation, for example, caused the House to overturn the committee's recommendation of rejection and, instead, adopt the resolution which requires that, during its first three years, in order to be represented in the OSMA House of Delegates, 50% of the physicians in the specialty society be members of the OSMA. Following that three-year term, the percentage of physicians with OSMA membership may be adjusted to equal the percentage of the total physician population in Ohio who are members of the OSMA.

Nermin Lavapies, MD, Seventh-District Councilor, and a member of the Ohio Academy of Family Practitioners, was one of many who urged the House to keep the eligibility requirements flexible. "We need more input from the specialty societies," she said.

Also receiving representation in the House were resident physicians — and a more detailed account of this new section is featured elsewhere in this issue.

Debate rose again on the issue of Spouse Active Membership. The intent of the resolution was to reduce the per capita dues and assessments for the two-physician-member household.

Speaking for the resolution, H. William Porterfield, MD, Tenth District Councilor, pointed out that the number of members of the OSMA often plays an important role in dealing with both the public and the legislature. "The OSMA should use every opportunity to swell its membership," he said, and added that reduced fees for spouses would be a good way for the OSMA to augment its position, without much cost to the association. J. Hutchison Williams, MD, dean of Student Affairs at the Ohio State University College of Medicine, also speaking for the resolution, said "it's a commonly-accepted fact that medical students marry medical students," and that such two-physician couples would



Members of the First District Delegation listen to the report given by one of the House's Resolution Committees.



Councilor and Delegate Stanley Lucas, MD, (left) refers to a Resolution under discussion.



Francis Waickman, MD, makes a point at microphone 1.

be encouraged to join OSMA if dues could be reduced.

However, Nancy Johnson, MD, a delegate from Cuyahoga County, announced that she works hard as a physician, and was "happy and proud to pay my full share of dues" — a remark that prompted applause from the House. Another delegate — from Butler County — asked the question "which income group is better able to pay — the two-physician family or the one-physician family?" and yet another asked which group would be considered next for reduced fees? The resolution was defeated, following Committee One's recommendation.

Perhaps one of the hottest resolutions considered by Committee One was Resolution 13-87 which called for the OSMA to support legislation eliminating further funding of Certificate of Need (CON) programs in Ohio.

Despite some discussion — pro

An Overview of Actions on Resolutions

Committee #1

00-87 — Resident Physician Section — **Adopted**
01-87 — Medical Specialty Society Representation — **Adopted**
02-87 — Specialty Society Representation — *called out of order by the chair*
03-87 — Medical Specialty Society Representation — *called out of order by the chair*
04-87 — Spouse Active Membership — **Defeated**
05-87 — Multi-County Membership — **Defeated**
06-87 — Study of Alternative structures — **Adopted**
07-87 — Physician Inclusion in Medicare DRG Program — **Adopted**
08-87 — OSRS Supports AMA Resolution 30 — *combined with 09-87*
09-87 — Physician DRG — *combined with 07-87*
10-87 — Second Opinion Plans — **Adopted**
11-87 — Rationing — **Adopted**
12-87 — Standardized Insurance Forms — **Adopted**
13-87 — CON Legislation — **Defeated**
14-87 — Opposition to Government Legislated Physician Fee Controls and Services Under Medicare — **Adopted**
15-87 — Assignment of Health Insurance Benefits — **Adopted**
16-87 — Catastrophic Health Insurance — *Referred to Council*
17-87 — Ohio State Medical Association Statewide PPO — *Referred to Council*
18-87 — Enrollment as Providers in the Third Party Payment Plans — **Defeated**
19-87 — Restore Private Ethical Medical Practice — **Defeated**
20-87 — Curtail "Fair Fee Support" Language — *Referred to Council*

Committee #2

21-87 — Annual Meeting — *Referred to Council*
22-87 — Swift Communication — **Defeated**
23-87 — OMPAC — **Adopted**
24-87 — AMA Representation — **Defeated**
25-87 — Women in Medicine Committees — **Defeated**
26-87 — Medical Staff By-Laws — **Adopted**
27-87 — Risk Pooling — *Referred to Council*
28-87 — The Hospital Medical Staff Independent Practice Corporation Concept — *Referred to Council*
29-87 — Peer Review of the performance of Hospital Medical Staff Physicians — *Referred to Council*
30-87 — Establishment of a Special Task Force for Foreign Medical Graduates — **Defeated**
31-87 — Fee Review by the Ohio State Medical Board — *Referred to Council*
32-87 — Opposition to Usage of SI Nomenclature — *Referred to Council*
33-87 — HB 150 Constitutional Malpractice — **Adopted**
34-87 — Patient Compensation Fund — *Referred to Council*
35-87 — Hospital Advertising — *See 56-87, Committee #3*
36-87 — Clinical Laboratory Certification — *Referred to Council*
37-87 — Mandatory Medicare Assignment for Medical Licensure in the State of Ohio — *combined with 33-87*
38-87 — Triage of Accident and Trauma Victims — **Defeated**
39-87 — Mandatory Medicare Assignment for Licensure or Relicensure — *combined with 33-87*

and con — on Saturday, the committee placed the resolution on its consent calendar with a recommendation to reject. However, it was pulled out for discussion on the floor Sunday. While, ultimately, the House defeated the resolution, various points were made, both for and against governmental and non-governmental health planning, well-illustrating the complex feelings on this matter. Daniel Deutschman, MD, for example, speaking as a member of the Ohio Psychiatric Association, said "state planning is best, especially in the area of mental health," and called attention to the five for-profit psychiatric institutions that are being built, without restrictions, around the state. However, John A. Devaney, MD, Fourth District Councilor, pointed out that the House is already on record for being in favor of non-governmental health planning, and should remain so.

The matters of mandated second opinions and health care rationing were also brought up for Committee One's consideration. The committee recommended that Resolution 10-87, calling for the OSMA to *support* voluntary patient or physician-generated second opinion programs, and *oppose* mandatory second opinion programs was passed with little discussion; as was Resolution 11-87, calling for the OSMA to develop informational materials which would explain to Ohio citizens the adverse effects of health care rationing.

Resolution 17-87, asking the OSMA to investigate, and, if feasible, to develop a statewide PPO, was referred to Council.

Resolutions Committee Two also had its share of topical issues — and debate was plentiful during hearings on Saturday.

Receiving a surprising amount of discussion was Resolution 25-87, which called for a statewide Women in Medicine Committee

and the encouragement of county-wide Women in Medicine programs, based, in part, on the success of the 400-member Women in Medicine Committee of the Academy of Medicine of Cincinnati. While the committee recommended referral of the resolution to Council, recognizing that the Membership Committee was currently addressing the issue, it did note "the importance of the growing women physician population, and the need to address their special concerns."

Deborah Mencer, MD, delegate from Union County, however, said she opposed the resolution for two reasons. "First, there is a feeling of discrimination when any group is segregated, and second, we should spend our money and efforts on important issues which affect physicians as a whole, and not on separate, internal issues." The House overturned the committee's recommendation, and defeated the resolution.

Similar to this discussion was the debate that followed introduction of Resolution 30-87, establishment of a special task force for foreign medical graduates (FMGs). Committee Two had placed this item on its consent calendar with a recommendation to adopt, however, it was removed and opened for discussion on the floor — where many of the points which had been raised against a Women in Medicine Committee were used to defeat this resolution.

"I feel it is discriminatory to build a special section for FMGs," said a delegate from the Sixth District. "As an FMG myself, I know what the problems are." But, he continued, this group was capable of solving its own problems. "FMGs are in the mainstream of American medicine, and I have not seen any action to deter FMGs from a leadership role. The need for a task force is more of a perceived need than a real need," he said.

However, Theodore Castele, MD, a delegate from the Fifth District, which offered the resolution, stood in support of the task force.

"Many of us feel that FMGs need special attention. Yes, as far as membership goes, the numbers are there, but they are not brought into leadership roles. They don't push themselves, and we believe they need to be shown how to get into the full stream of medicine."

But the Sixth District countered, again, with arguments against.

"Leadership can't be given away," came the argument. "FMGs should come forward and do what they are supposed to do."

Also sparking debate on the floor was Resolution 32-87, Opposition to Usage of SI Nomenclature. The resolution, submitted, again, by the Fifth District, called for the OSMA to adopt an official position opposing all efforts to adopt SI units as a standard nomenclature, and support retention of the mass-based nomenclature.

Opponents to the resolution likened the situation to America's

"There is a feeling of discrimination when any group is segregated . . . we should spend our efforts on issues which affect physicians as a whole . . ."

An Overview of Actions . . . *continued*

Committee #3

40-87 — AIDS Campaign — **Adopted**
41-87 — Health Education on AIDS in Public Schools — **Defeated**
42-87 — Community Liaison Regarding AIDS — **Adopted**
43-87 — Alcohol Treatment — **Adopted**
44-87 — Reaffirmation of Resolution No. 58-84: Public Purchase and Consumption of Alcoholic Beverages — **Adopted**
45-87 — Mail Order Prescriptions — *Referred to Council*
46-87 — Office Dispensing of Prescription Drugs — **Adopted**
47-87 — Third-Party Interference with Physician Prescribing Patterns — *Referred to Council*
48-87 — Labeling of Generic Substitutions — **Adopted**
49-87 — Parking for Temporarily Handicapped — **Adopted**
50-87 — Bedside Blood Glucose Monitoring in Hospitalized Diabetic Patients — **Defeated**
51-87 — Statewide Ethics Committee — **Adopted**
52-87 — Reaffirmation of Resolution No. 46-84: Mandatory Use of Protective Helmets for Motorcyclists — **Adopted**
53-87 — Civil Aeromedical Helicopter Industry Safety — *Referred to Council*
54-87 — Continual Medical and Patient Education Socio-Political Economic Topics — *Referred to Council*
55-87 — Early Detection — **Adopted**
56-87 — OSMA Policy on Advertising — **Adopted**
57-87 — Student-to-Student Community Health Education Project — **Adopted**
58-87 — Smoke-Free Environment — **Adopted**

— *Karen S. Edwards*



Above: Jerry Hammond, MD, explains voting procedures to the House.

refusal to use the metric system. "Here we are, trying to buck the trend again," remarked a delegate from the Second District. Another added that "it's about time we aligned ourselves with progress. Just because we are uncomfortable with the units is no reason to reject them."

"But if it's fixed, don't break it," came the argument in favor of the resolution. "There is no logical reason for substituting this (form of measurement)." In fact, proponents were quick to point out that slippage or errors could easily happen, and a patient could be harmed.

Because feelings on both sides appeared to be strong, the House finally referred the matter to Council for further study.

One resolution which had no trouble passing, either out of committee hearings or on the floor, was the resolution dealing with mandatory Medicare assignment for medical licensure in the state of Ohio.

Committee Two had combined Resolution 33-87, HB 150 Constitutional Malpractice; Resolution 37-87, Mandatory Medicare Assignment for Licensure; and Resolution 39-87, Mandatory Medicare Assignment for Licensure or Relicensure into Substitute Resolution 33-87. This substitute resolution called for the OSMA to actively oppose HB 150 and any other legislation that would propose mandatory Medicare assignment as a requirement for licensure. Further, it stated that if the bill should be enacted, the OSMA should take immediate court action to nullify the law, seeking appropriate interest groups to assist with the court action if necessary. Despite a rather hefty fiscal note attached to the resolution — $10,000-$50,000, depending on the extent of legal activities — it was passed without debate.

Resolution Committee Three had a number of interesting issues before it — and perhaps none more interesting than the two which dealt with prescription drugs.

Below: Medical students caucus before their resolution is brought to the House floor for discussion.



Resolution 45-87 focused specifically on mail order prescription drugs. Discussion of this topic was heavy.

Resolution 45-87 focused specifically on mail-order prescription drugs and the fact that increasing numbers of third-party carriers and self-insured companies are creating financial incentives for patients to use out-of-state suppliers and a full three-month supply of the drug

prescribed. The resolution stated its concern that the physician not only has no means of quality control concerning the product dispensed, but, because of the methods of labeling frequently used with these products, drug identification was often "difficult to impossible." The resolution called for three things — 1.) that the OSMA use its influence to assure all out-of-state suppliers are licensed under Ohio law; 2.) that each supplier be required to furnish both patient and prescribing physician with an exact record of the product, its manufacturer, appearance and identification codes, a copy of the label used on the prescription package, and directions for use; and 3.) that data be obtained (in cooperation with the Ohio State Pharmaceutical Association) on the exact costs of bulk prescribing versus routine drug supply, and that this information be made available to county medical societies.

Discussion of this topic was heavy during committee hearings on Saturday, and the committee, recognizing the complexity of the issues, recommended that the resolution be referred to Council. The House agreed with the committee and passed the matter on to Council for consideration "as soon as possible."

However, amended Resolution 46-87, Office Dispensing of Prescription Drugs, was passed, following the committee's recommendation on the matter. The amended resolution asked the OSMA to develop guidelines, based on legal and ethical considerations, for those physicians who choose to dispense drugs in their offices, and for the publication of these guidelines "for the benefit of all physicians in Ohio."

Committee Three was also handed the responsibility of considering three separate



Donavin Baumgartner, Jr., MD, delivers a brief speech after being elected OSMA's new President-Elect.

Election Results . . .

The position of President-Elect was filled on Sunday afternoon by *Donavin A. Baumgartner, Jr., MD* of Cleveland.

In other election proceedings conducted at the House:

The following were elected Councilors from even-numbered districts for a two-year term:

Second District — William J. Marshall, MD
Fourth District — John A. Devany, MD
Sixth District — J. James Anderson, MD
Eighth District — John F. Kroner, Jr., MD
Tenth District — William H. Porterfield, MD
Twelfth District — Jack L. Summers, MD

For delegate to the AMA (serving a term commencing May 17, 1987 and ending December 31, 1987), the following were chosen:

A. Robert Davies, MD
Claire V. Wolfe, MD

For delegate to the AMA (serving a term commencing January 1, 1988 and ending December 31, 1989), the following were elected:

John E. Albers, MD
Oscar W. Clarke, MD
William Dorner, Jr., MD
John J. Gaughan, MD
B. Leslie Huffman, MD
Joseph Sudimack, Jr., MD
A. Robert Davies, MD
Edward G. Kilroy, MD
Claire V. Wolfe, MD

For delegate to the AMA (serving a term commencing May 17, 1987 and ending December 31, 1988) the following were chosen:

Stanley J. Lucas, MD
Richard J. Nowak, MD

The Installation of D. Ross Irons, MD



Above: D. Ross Irons, MD, addresses the House as his wife, Becky, and four of their children look on.

Below: Herman I. Abromowitz, MD, installs D. Ross Irons, MD, as OSMA's new President.



resolutions submitted on the subject of AIDS Education.

Resolution 40-87, AIDS Campaign; 41-87, Health Education on AIDS in Public Schools; and 42-87, Community Liaison Regarding AIDS were combined for Saturday's hearings, but were brought up as separate issues on the floor of the House. The resolution concerning the AIDS campaign was slightly amended by the time it reached the House, but it called for the OSMA to: support proclamation of AIDS as a national medical concern; support the establishment of multiple testing centers; encourage voluntary testing in all high-risk groups; support programs for case reporting and contact tracing and notification; and lobby for federal, state and local funds for AIDS education programs to schools, colleges and the news media. This resolution was passed by the House, along with Resolution 42-87, which encouraged county medical societies to establish an AIDS information section and resource person/committee which would serve as a liaison with community AIDS task forces and the OSMA Task Force on AIDS. Since the subject of Resolution 41-87, calling for increased educational efforts on AIDS, was addressed in the adopted resolution 40-87, it was deemed unnecessary by both the House and committee and defeated.

Also considered by Committee Three were two resolutions dealing with alcohol sales. Resolution 43-87, endorsed legislation for an added state tax on the sale of all alcoholic beverages to help cover the cost of alcohol treatment programs. Once the House determined that the sale applied to all packaged alcoholic beverages (and not by the glass in a tavern), the resolution was adopted. Also adopted was Resolution 44-87, which reaffirmed the stand the OSMA House took in 1984, which favored raising the legal drinking

age in Ohio to 21 years.

Although parking for the temporarily handicapped sparked some debate on Saturday, Committee Three recommended adoption of Resolution 49-87 which supported legislative efforts to accelerate the issuance of handicapped parking permits to temporarily handicapped patients. Various speakers on Saturday, however, raised the issue of abuse by permit holders.

"There is, of course, the danger that the market will be flooded with handicap permits," said Stanley Fox, MD, of the Fifth District. He recommended that these permits be printed with expiration dates. Another speaker on Saturday worried that temporary permits might encourage some patients to drive "who shouldn't really be driving." Nevertheless, the resolution was adopted by the House.

Resolution 51-87, calling for a statewide ethics committee also generated much discussion on Saturday, but little at the House on Sunday. Committee Three, however, had amended the resolution to read "that the proposed ethics committee be composed of OSMA members, but avail itself of a broad base of resource people, including, but not limited to, lawyers, clergy, hospital representatives, ethicists and consumers." As such, the

"There is, of course, the danger that the market will be flooded with handicap permits."

resolution was adopted by the House.

The Medical Student Section's resolution calling for an investigation of civil aeromedical helicopter safety was referred to



Above: Members of the Eleventh District consider one of this year's resolutions.



John Thomas, MD, (left) and Carlos Andarsio, MD, (right) provided testimony during the proceedings.

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Council for review. In its report to the House, Committee Three noted that the "complexities of this issue, including the question of government jurisdiction, warranted further study." However, the House did give a round of applause to the Medical Student Section's Resolution 57-87, which asked the OSMA to support (in spirit as well as with some financial assistance) the Student-to-Student Health Education Project launched by medical students at the Medical College of Ohio at Toledo. The students hope to take the project to both a state and nationwide level soon. (Watch for coverage of the project in a future issue of *OHIO Medicine*.)

Also earning a round of applause, but at the Saturday hearings, not on the House floor, was OSMA Past President John Budd's testimony on Resolution 35-87, hospital advertising. The resolution had been combined by the committee with resolution 56-87, OSMA Policy on Advertising — but it was specifically the hospital advertising issue which Dr. Budd addressed. He stood before the committee and, in his own inimitable style, read eight pages of hospital advertisements "which promised to cure everything from obesity to impotency," he said.

The ads promised to cure everything from obesity to impotency . . .

The resolution arrived at the House Sunday in the form of substitute resolution 35-87 — which called for OSMA members who wish to market their services, to adopt practices which "are not false, fraudulent, deceptive or misleading," and "to give the public adequate information" which would allow them to make "informed choices" about their health care providers. And, "Resolved: That the OSMA examine the issue of hospital advertising." The resolution was adopted.

In its final action, the House voted to adopt Resolution 58-87, Smoke-Free Environment, which calls for the OSMA to work with the Ohio Hospital Association to effect a smoke-free environment in all Ohio hospitals.

Said Claire Wolfe, MD, Tenth District delegate in testimony to the committee on Saturday: "I can't conceive why the hospitals aren't moving faster on this." **OSMA**



The Election Committee, led by Claire Wolfe, MD, (far right) tallies votes.



Bob Clinger, (far left) Director of OSMA's Department of Medical Society and Member Relations, meets with some of the County Society Executives during the House.

Karen S. Edwards is the Executive Editor of **OHIO Medicine.**

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Resident Physician Section

By Bronn Rayne, MD

The OSMA Annual Meeting was held in Columbus, in May, during which the House of Delegates passed Resolution 00-87, establishing a Resident Physicians Section within the OSMA. This is a supportive gesture for increasing the involvement and initiative of the residents and fellows in the matters of the local, state and national medical front.

Any resident or fellow in an Ohio training program is eligible to join the local, state and national medical associations and consequently become a member of the RPS. With increased resident participation in the OSMA-RPS, we can help identify and understand the problems facing the medical field and then work toward forming a unified, sound position on pertinent matters — ultimately leading to solid suggestions for improvement, in the form of resolutions or reports.

The formation of the OSMA-RPS follows in the tradition of the AMA-RPS — set up by the AMA to encourage direct communications between the growing organized body of fellows and residents and the major body representing the majority of the physicians in the U.S. Direct representation in the OSMA House of Delegates by fully privileged voting representatives of the RPS will aid the unity and strength of the medical society. The resident membership is for the duration of the training period through the fellowship years, and there will be annual OSMA-RPS meetings at which officers and representatives are elected and resolutions and reports are considered.

Authority to submit resolutions to the OSMA-RPS on specific views or items of impact pertaining to any subject is afforded any OSMA-RPS member. If these resolutions are accepted by a majority at the RPS meeting, they may be submitted to the OSMA House of Delegates for consideration. It is through these avenues of communication that a concept is conveyed to the state and national medical society. At the 1986 AMA-RPS interim meeting, resolutions embracing the issues of teenage pregnancy, tax deferral status of student loans, organ donor programs, shared residency programs and other subjects were adopted and several will be submitted to the 1987 AMA-House of Delegates Annual Meeting.

Opportunities to serve on OSMA committees and AMA committees are also available and encouraged by the RPS for its members. These are critical areas of representation needed to keep abreast of the rapidly changing state and national medical policy. With interested, active members, the Resident Physician Section can achieve many goals and aid in the progress of organized medicine. The understanding of medical policy and policy-making procedures will also aid us in taking a responsible role in the national medical arena once we finish training and join the "real world of medicine."

I urge all residents to contact their local medical association representatives or program directors and investigate what the OSMA-RPS — with all of its benefit programs — can do for them. And while discussing what you can get from the RPS, think of joining and becoming an active advocate for medical policy programs — now and in the future. **OSMA**

Bronn Rayne, MD, is chairman of the Resident Physician Committee of the Ohio State Medical Association.

The Peer Review Process: New Focus, New Directions

By David Sweet

The words from Thomas Stevenson, MD, were not encouraging.

"Tell your medical staffs this (peer review) is not going to go away."

Dr. Stevenson is chairman of the Central Regional Quality Review Committee at Peer Review Systems, Inc., and one of four panel members who discussed "PRO Review Process and Sanctions" at the OSMA's Hospital Medical Staff Section's Annual Meeting, held in conjunction with the OSMA's Annual Meeting this past May.

But Dr. Stevenson was not alone in his opinion that peer review is here to stay. Barbara Gagel, regional administrator of the Health Care Financing Administration (HCFA) agreed with Dr. Stevenson, and encouraged Ohio physicians to become involved in the peer review process. "It's either going to be done by your peers who are on staff on hospitals around the state of Ohio, or it's going to be done by employed physicians working at the PRO," she said.

The reason PROs exist, explained Dr. Stevenson, is because politicians have the conception that substandard care exists at substantial levels. "We, as a profession — individually and collectively — have not done enough to dispel that perception," he said. Therefore, "the federal government has intervened to ensure quality of care."

In fact, assuring quality care has become the new focus of the PRO program, said Gagel. Two years ago, she continued, Congress was concerned about over-utilization of health care and, as a result, initiated the prospective payment system to control the length of hospital stays. "PROs were expected to protect the PPS program, and it has done a good job of doing that," she added.

But recently, concern has shifted to the impact the prospective payment system has had on the quality of care. Now, she said, the new focus of PROs will be on assuring and maintaining quality health care — an element that was missing from the first two years of the program.

HCFA is also expected to implement other changes in the PRO program in the near future. For example:

- As of March 1, 1987, PROs are now required to review all requests for using assistants in cataract surgery. Prior approval is needed for the use of an assistant, otherwise, said Gagel, payment will be denied.
- Proposed changes will give PROs the power to deny payment for substandard care — authority which has come about only recently. However, two controversial issues are presently keeping these changes from taking effect. The first has to do with the requirement that patients be notified that the care they received from a physician was substandard. A "letter of notification" is being written, and Gagel hopes it will be available for comment soon — but, of course, the wording of the letter is not the only concern health care professionals have with it. The second issue of contention is how PROs will establish criteria for judging "substandard" care. Currently, said Gagel, the changes call for the case to be reviewed by a specialist in the same field, and then discussed with the attending physician prior to denial of payments.
- Another change just implemented is pre-admission or pre-procedure review for elective surgical procedures — with a second surgical opinion required in some cases. These reviews, implemented in May, include surgical procedures done in hospitals *and* in ambulatory surgery centers.

PROs will also review services provided in hospital outpatient departments and in ambulatory surgery centers, effective for all PRO contracts signed from now on. This review will not, however,

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Otitis media due to *S pneumoniae, Haemophilus influenzae,* staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin-structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis,* and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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be implemented in Ohio until a new PRO contract goes into effect.

• A major change that will also take effect with all contracts signed from now on, is the review of all re-admissions within 31 days of discharge. Two years ago, the review period was within only seven days; now it is within 15 days. According to Gagel, all intervening care (post-hospital) between discharge and re-admission will also be reviewed, regardless of who provides the care. For contracts signed after January 1989, PROs will also look at the care provided in physicians' offices during the period between discharge and re-admission.

• The last change — to be implemented by August 1, — is PRO review of Health Maintenance Organization care, and HCFA is now in the process of reviewing bids of organizations to review HMOs. "An in-hospital stay will trigger this review," said Gagel, — "but we will look at all aspects."

In defense of the PRO program, however, Gagel says that "contrary to popular belief," HCFA does not judge PROs on the number of denial notices they issue, or by the number of sanctions that are issued. "Sanctions are a last resort, to be used after education is not successful," she says.

In fact, as of March, 1987, only 62 U.S. physicians (of more than 340,000) have been sanctioned as a result of PRO action. "We don't exactly have a witchhunt going on," she notes. In comparison, however, from 1973 to 1984, review agencies disciplined only 70 doctors or hospitals, by barring them — either temporarily or permanently — from treating Medicare patients.

Dudley Briggs, MD, chairman of Peer Review Systems, Inc., the PRO for the state of Ohio, agrees.

"We had to go into a competitive bidding process, because we (PRS Inc.) were being told we weren't aggressive enough in 'going after' doctors," he says. To illustrate, he also points to sanction figures in Ohio. "From August 1985, when the sanction process began, to March 1987, there have been 810,000 Medicare hospitalizations in the state. Of that, 241,000 or 30% have been reviewed — and of that 241,000, 2,000 have been referred to the Regional Quality Review Committee for evaluation."

Only four sanctions have resulted in Ohio so far, and of those sanction actions, two have been approved by the Office of the Inspector General (OIG) and two are pending. The first two approved by OIG are now under appeal to an administrative law judge. Thirteen discussional meetings have also been held with physicians to discuss actions in the sanction process.

"We view the sanction process as the failure of the peer review program," Dr. Briggs states. "We continue to seek to resolve all the issues by education and look to the sanction process as the last resort."

PROs: A Short History

Ever since the federal government created the Medicare and Medicaid programs, there have been efforts to influence the use of these programs by reviewing reimbursement to physicians and hospitals.

At first, this responsibility was shared by insurance companies, states and hospital utilization review committees. This soon proved to be unsatisfactory. In 1972, Congress passed the Professional Standards Review Organizations (PRSOs) Act, which tried to nationalize utilization review programs. This act encouraged physician-directed organizations to apply for grants to establish local criteria for Medicare and Medicaid patient care review. Nearly a decade later, PRSOs had been formed in 187 of 195 designated areas.

As is the case today with PROs, PRSOs were regarded by many as cost controlling agencies. When the Health Care Financing Administration was created in 1977, PRSOs fell under its jurisdiction. Negative sentiments and questions of effectiveness caused the Reagan administration to push for the termination of the program in 1982. After congressional debate, one-third of the PRSOs were eliminated in 1983.

The Tax Equity and Federal Responsibility Act, passed in 1982, called for the development of a prospective payment system and linkage to "utilization and quality control peer review organizations." The Deficit Reduction Act, which established pre-determined payments for hospital admission of Medicare patients in nearly 500 diagnosis-related groups (DRGs), was passed in October 1983. These new laws were welcomed by some and frowned upon by many.

In early 1984, HFCA solicited proposals from utilization and quality control peer review organizations, now called PROs. To qualify for the new program, the organizations have to show either physician sponsorship by a substantial number of physicians in the area, (at least 10%), or physician access. Access refers to the involvement of representatives of at least 17 specialties.

The first PRO contract was approved as of July 1, 1984. The final three of the 54 areas were awarded contracts in November of the same year. As these new contracts were awarded, the old PRSOs were terminated. Since then, PROs have been at the forefront of controversy, accused of sacrificing the quality of patient care for cost controls. The debate continues. — *David Sweet*

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	You	Spouse
Amount of coverage ($50,000 minimum)	$ _____	$ _____
Birth date	__/__/__	__/__/__
Sex	☐ M ☐ F	☐ M ☐ F
Smoked cigarettes last 12 months	☐ yes ☐ no	☐ yes ☐ no
Coverage needed by	__/__/__	__/__/__

The Peer Review Process

continued

Part of that educational process involves informing doctors that the Medicare program will only reimburse for services that are (a) furnished economically and only when and to the extent medically necessary; (b) on a quality level that is professionally recognized in the health care field; and (c) supported by evidence of the medical necessity and quality of the services in the form and fashion that the reviewing PRO may reasonably require.

A PRO can instigate the sanction process if it finds the health care provider or practitioner has either "failed substantially to comply with any obligation in a substantial number of cases," or "grossly and flagrantly violated any obligation in one or more instances."

The first type of violation refers to care that is deemed unnecessary, is not properly documented in the patient or patients' records, and/or is inappropriate or below the established level of professional standards of care.

A "gross and flagrant" violation is an infraction that has happened more than once, and has placed the patient's health, safety, or well-being in imminent danger or in an unnecessarily high-risk situation.

But the term "gross and flagrant violation of obligations" is not a concrete definition, says attorney William Todd, also a panel member at the Hospital Medical Staff Section meeting.

Still, once it has been decided that a provider or practitioner has violated one of these two directives, a letter is sent to the practitioner — letters which Dr. Stevenson says are all too often ignored, or taken lightly by those in the profession.

"We know that the evaluation of a medical record is a very difficult way to evaluate the quality of care," he says, which is why the review board attempts to contact the physician to obtain further information about the care in question. Many times, however, when the committee writes to a

physician, the committee never receives a reply.

Then, "PRS assumes that 1.) maybe the physician didn't get the letter, or 2.) that the physician felt 'I'm not going to pay any attention to those people down there — and to hell with it,' or 3.) they put off correspondence until a later date," says Dr. Stevenson. But if they don't hear from the physician eventually, PRS will assume that the physician doesn't care.

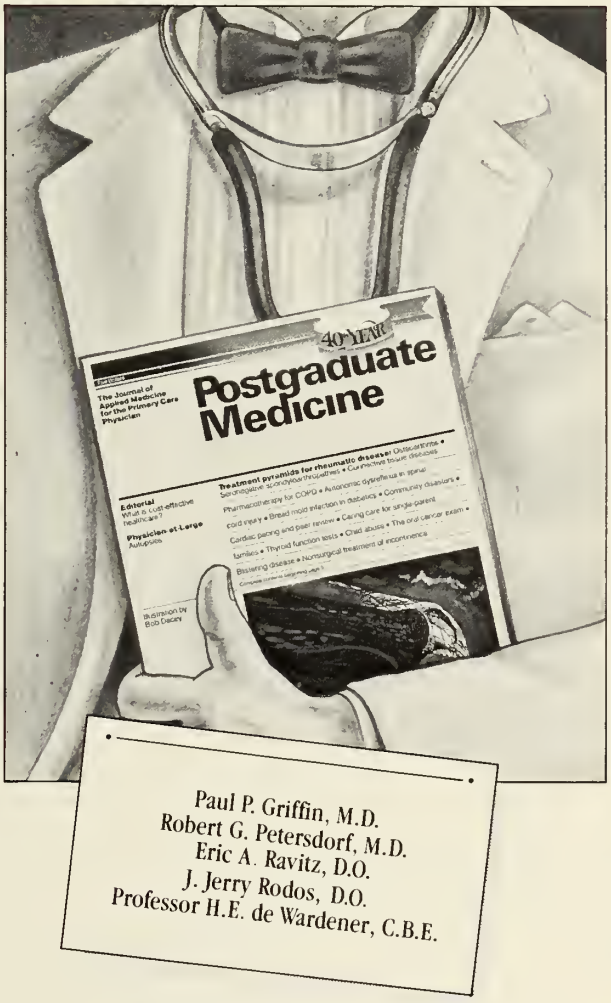
Of course, non-response is not the only response to PRS letters, however. Dr. Stevenson says peer reviewers also get angry, hostile replies, ranging from "who in the hell are you?" and "what are your qualifications?" to "if you knew anything, you would already know the answer." As frustrating as the review process can be, however, Dr. Stevenson urges Ohio physicians to cooperate with PRS — "even though the review process may leave much to be desired," he comments.

In return, HCFA *is* trying to make the system more palatable to the physician population. As of May 13, for example, HCFA and the Office of the Inspector General reached an agreement with the AMA on new measures to improve the sanction process, — prompting the AMA, along with the American Association of Retired Persons, to drop the lawsuit they had pending against HCFA and the OIG. Both sides are now optimistic that the changes will obtain more due process for physicians involved with the sanction procedures.

One of the first changes to be implemented, for example, is the drafting of a new letter to inform physicians or hospitals that they are being considered for sanction. "It's intended to solve communication problems," Gagel says, explaining that the new letter makes it very clear that the sanction process is serious business.

Another change is that the accused physician now has a right

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to have an attorney present, the right to present expert witnesses and the right to a transcript of his or her meeting with the PRO physician panel. Also, the PRO must exclude from the recommending panel any physician who may be biased or who competes with the physician under accusation, and the reviewer who initiated action is given no voice on the final decision of whether or not sanction is imposed.

In addition, physicians are now given the opportunity to submit additional information to the PRO in the pre-sanction period — allowing the physician a chance to tell his or her side of the story and possibly prevent sanction measures from being taken.

If sanctions *are* taken, however, the steps of the sanction process are as follows — first, a nurse reviewer applies generic screens to all Medicare cases. If the screen indicates something out of the ordinary, the case is sent to a physician adviser who reviews it. If the physician adviser has doubts about the care provided, the case is then sent to the Regional Quality Review Committee. Once the case reaches the committee, it is referred to a doctor of the same specialty as the physician under review.

If further questions remain, the case is then sent to the State Quality Review Committee, which will put it into one of four categories. Letters of inquiry are then sent to the physician, notifying him or her that the case is in the review process. The report of the committee's specialist is also included in the letter.

If the issue is not resolved at this point, the case can then be processed for sanction. After the physician is notified, he or she is allowed to submit additional information that might help the committee in its determination.

Todd, a partner in the law firm Porter, Wright, Morris and Arthur, who has represented Ohio physicians in medical malpractice cases, agrees that physicians must cooperate with the review process, especially when they receive the notification letter from the PRO.

"At first, you will have no knowledge that your files are being reviewed," Todd says. "Up until then, it (the review) has been a cold chart review." Good records may help your cause, though, notes Todd, and he urges physicians to document the need for procedures they've ordered right on the chart. If you are notorious for keeping bad records, however, Todd warns you to watch out.

"You don't know your accuser, you don't even have as much protection as you would in a medical malpractice case," he says. In fact, he adds, "you have fewer rights (in the review process) than you do in court." He urges physicians to retain legal counsel during the review process as soon as they are notified they are being considered for sanction. He also

continued on page 485

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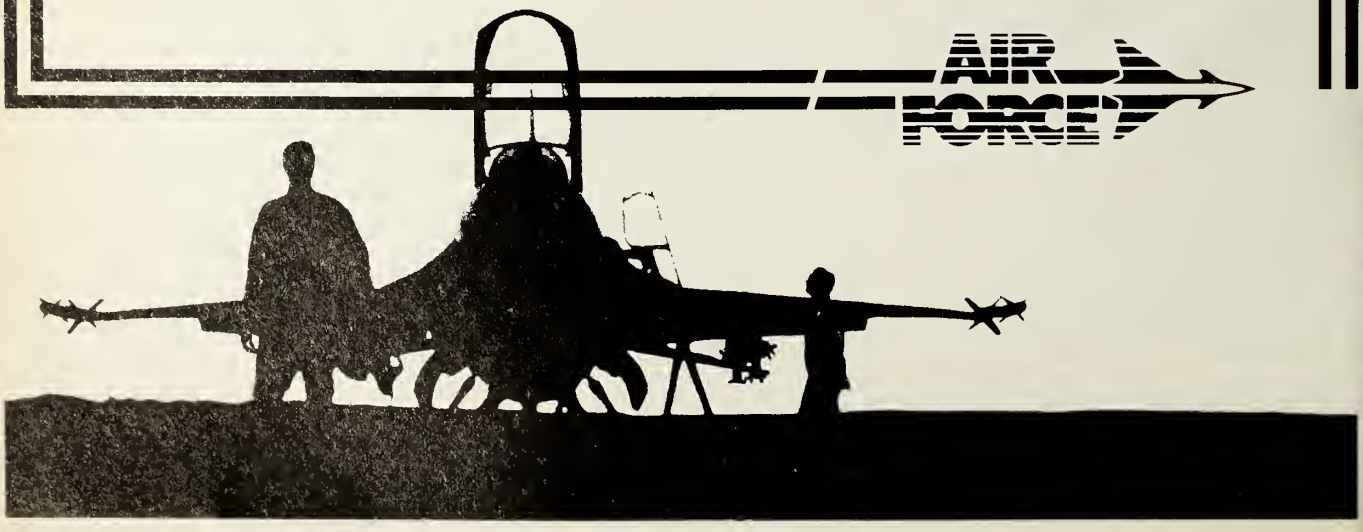
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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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ADVERSE REACTIONS:
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Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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Frazzled Phrases:

Quips and Quotes from OSMA Members

Collected by Herbert E. Gillen

There is one constant in the life of a medical society executive: meetings. There are meetings to plan meetings, meetings to postpone meetings and meetings to avoid having a meeting.

In that regard, Herbert E. Gillen, Executive Director of the OSMA, is a typical medical society executive. In his twenty years of service to the organization, he has attended more than his share of meetings. About 10 years ago he started jotting down "frazzled phrases," comments and observations he heard in meetings which caught his ear.

For your enlightenment and enjoyment, the best of the crop are listed below. If any look familiar, don't be surprised. If you were ever in a meeting with Herb, and waxed poetic, then you may find your words listed here.

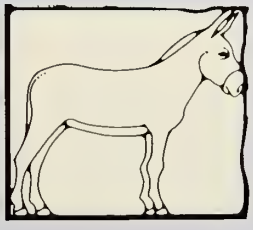
ADVICE

If you're looking for advice, forget Dear Abby, medical meetings are an untapped source for free advice.

The only way to get a kick in the fanny is by being out front.

You can't enjoy the rainbow until you've been through the thunderstorm.

When there are 100 remedies, none of them are any good.



The second kick by a mule is not a learning experience.

Very few people listen themselves into trouble.

When you throw mud, you lose ground.

When things are bad, we must act like the duck, be serene and calm above the water, but below we're paddling like hell to stay afloat.

If you're going to declare war you better have an army and be prepared to feed it.

There's got to be a stick along with the carrot.

Even the in-coming tide eventually goes out.

Seldom can you win a game by being a spectator.

If you just tread water you will be swept out to sea.

You don't put out a fire by throwing gasoline on it.

When you're in a depression, you don't buy Cadillacs.

If you work in the vineyard, you should taste the wine.

When there are more questions than answers, be sure you are the one asking the questions.

Those hooting with owls cannot expect to soar with eagles.



To be a big flea, you have to associate with big dogs.

You don't insult the crocodile until you are on the other side of the river.

You can shear a sheep several times, but you can only skin him once.

The secret of life is to die young as old as possible.

It's too late to review General Custer's battle plan.

ANALOGIES

Analogies are another popular form of expression in meetings.

It's like asking for volunteers to pull the switch on the electric chair.

That's like shooting paper wads at a battle ship.

It's like emptying the ocean with a teaspoon.

It's like being a maitre d' in a bad restaurant.

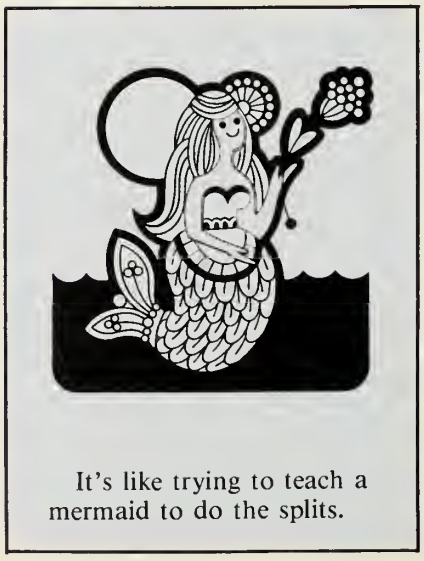
It's like looking into a keyhole to get a better look.

It's like rearranging the deck chairs on the Titanic.

It's like turning on the runway lights for Amelia Earhart.

It's like squeezing a balloon; what you get rid of in one place pops up somewhere else.

It's like taking a correspondence course in weightlifting. It's no help to you, but you should see the mailman.



It's like trying to teach a mermaid to do the splits.

Ohio's rich agricultural heritage seems to be reflected in the fact that animal-related analogies are particularly popular.

It's like turning a turkey loose in a corn field.

That's like putting lipstick on a pig.

It's like cutting off the cow's tail to find the udder.

That's like eating your seed corn.



It's like the eggs and ham you have for breakfast — the chicken makes a small contribution but the pig gives a total commitment.

OBSERVATIONS

Observations — both great and small — also seem to be a popular form of expression.

All of our problems come from solutions.

It's not a question of black and white, but rather shades of grey.

Each one of us has a certain amount of larceny in our hearts.

That does nothing more than change the stripes to spots.

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Frazzled Phrases . . . *continued*

We've created a two-legged stool.

It generated more heat than light.

Last year we were drinking the wine; this year we're stomping the grapes.

They may be convinced, but I don't see any of them making plowshares out of their swords.

It's like a lighthouse in the stormy seas of governmental intrusion.

You're throwing kindling on a fire already out of control.

We are using a 45 mm cannon to kill a mouse.

We're not moving mountains — we're decorating them.

It's like kissing your mother — it's nice, but it doesn't do much for you.

Ignorance gets us in trouble — arrogance keeps us there.

They don't see the light until they feel the heat.

We shot ourselves in the foot.

The future isn't what it used to be.

They're using an elephant gun to kill a flea.

We are not convincing when we sulk.



Let's count noses before we declare war.

People drive through roadblocks all the time.

We've all got to sing out of the same song book.

It looks like your end of the canoe is leaking.

We are losing time preaching to the choir.

They're playing "coalition" baseball.

Let's have a trial and hang the SOB.

And, again, the farm seems to be a major source of inspiration.

We've picked the peaches before they got fuzzy.

We've just given birth to a litter of apple pies.

We're the turkey being sliced.

They have the vehicle — they just don't have the horses to pull it.

It's not just a coincidence that many of the observations seem to hold particularly true for medicine. Herb attends medical meetings almost exclusively.

You should never leave the room when committees are being appointed.

Just when we know all the answers — they change the questions.

I think we have paralysis of analysis.

We're going to have to smile more and earn less.

We've got them right where they want us.

It appears a majority will lock arms and go over the cliff together.

We should not get on this bandwagon until we see where it is going.

Since we are all thoroughly confused, it must be time to vote.

DESCRIPTION

Physicians seem to be very fond of phrases to describe themselves.

I don't like anything I've said — but I said it.

I contributed to their ignorance.

I'm enlightened but not convinced.

I can see I'm swimming upstream.

I'm speaking my mind; I have nothing to lose.

I found a lot of soft and slippery semantics in the report.

. . . Or describing someone else.

He came out smelling like a herring.

It takes two hands for him to find his hip pocket.

He frequently plumbs the depth of his ignorance.

He snatched mediocrity from the hands of excellence.

We need to get him a job on the night shift painting lines on the freeway.



He's as nervous as a longtailed cat in a room full of rocking chairs.

His elevator does not stop at every floor.

Sometimes even the best intentioned phrase just goes wrong somewhere.

We're cleaning our house after the horse is out of the barn.

If people don't want to come out to the ballpark, nobody's going to stop them.

A few salvos have been cast upon the waters.

You can swim in the creek, or get out.

That takes a lot more fertilizer than we will ever get back.

That's like opening a box of pandoras.

It's another situation where the buffalo is pointed in the wrong direction.

It's one of those issues you take to the tub and sink.

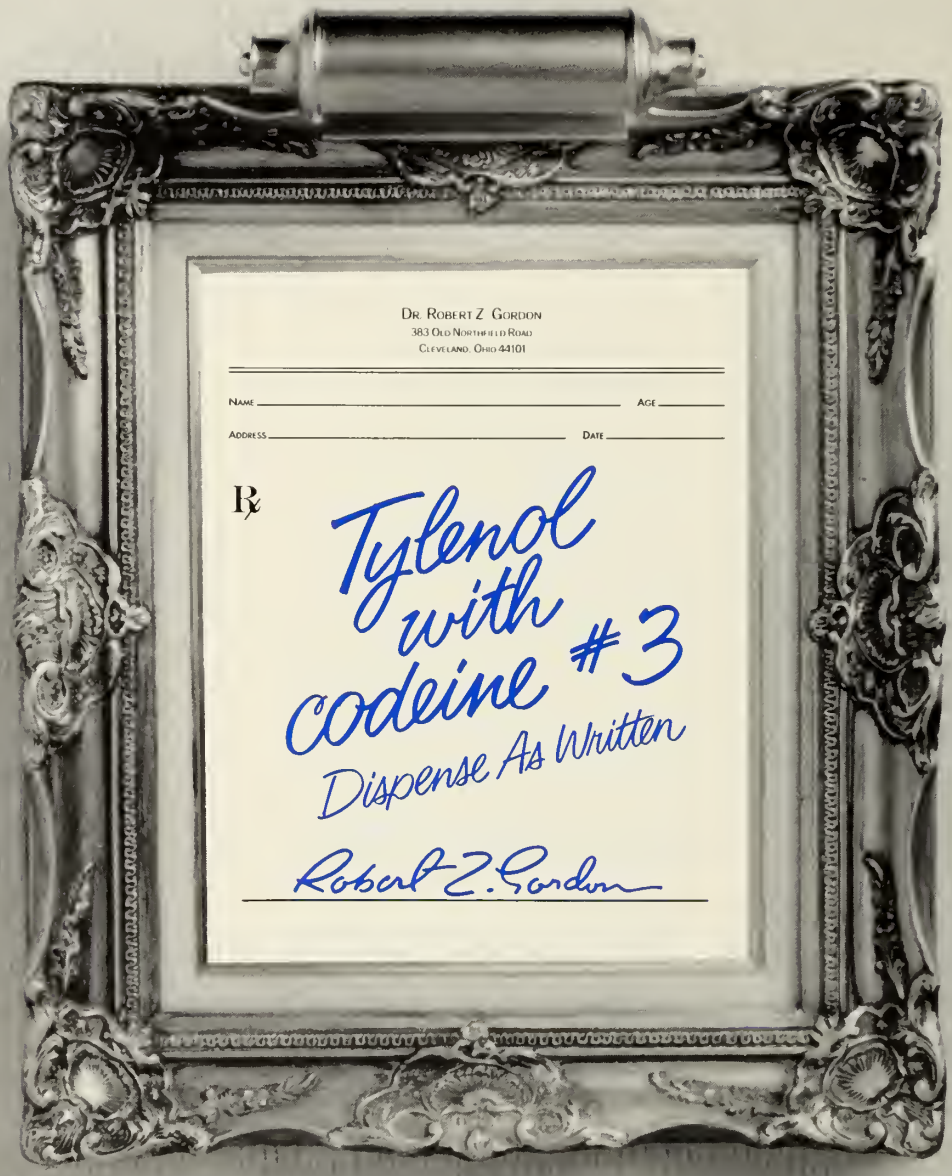
There are several ways to kill a dead horse.

At the bottom of the well there is a different form of water.

We have to have our chickens in the bag before we walk in.

We must keep our eye on the doughnut hole.

You should probably keep your eye on Herb. He's working on volume number two of "fractured phrases" and just waiting for your next remark. OSMA



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Through the Grapevines

By Deborah Athy

For some people, a good wine is anything that comes with a cork . . . but for the wine connoisseur, the proof is in the body, the bouquet and — above all — the taste.

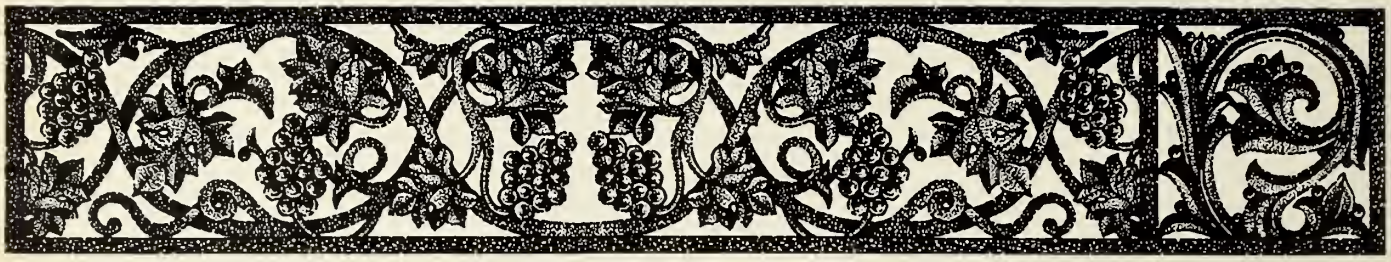
Wine is one of society's aristocrats — like caviar, opera, Brie — which has earned the reputation of having to be gradually and sometimes painstakingly appreciated. One has to *acquire* a taste for it, or so it's said.

But how does one go about "acquiring" a taste for wine — an *educated* taste, that is — acquiring enough background to know that "soda pop" wines like *Boonesfarm* are too sweet, while some dessert wines are just sweet enough.

Taking a wine appreciation class "speeds up the learning process considerably," says Donavin A. Baumgartner, Jr., MD, OSMA president-elect and Cleveland wine afficiando. "In one class, you can learn what would take a couple years of random testing to learn."

In addition to practicing trauma surgery and emergency medicine, Dr. Baumgartner teaches two wine appreciation classes per year — one beginner, one intermediate — at the Shaker Heights Recreation Board, an adult education program.

Most people probably start out preferring wines with a little more sugar, Dr. Baumgartner says. "They say they like dry wines, but they'll pick a wine which has a



From the Cellars of . . . Donavin Baumgartner

At the recent 1987 Annual Meeting in Columbus, Thomas Morgan, MD, chairman of the OSMA's Committee on Membership, nominated Donavin Baumgartner, Jr., MD, for the office of president-elect. In referring to Dr. Baumgartner's "fascinating hobby of wine appreciation," he said, "If OSMA members need advice on wine selection, Dr. Baumgartner will gladly offer his expertise in this area."

Dr. Baumgartner has met this challenge by compiling the following list of wine recommendations. "Rather than attempt a 'Top 10' type of list, I have included a somewhat random listing, not meant to be in order and not exhaustive, but that might be of interest," he writes.

California wines
Cabernet
Burgess, Clos du Val, Beaulieu Vineyards, Robert Mondavi, Diamond Creek, Silver Oak, Caymus, Boeger and Flora Springs
Zinfandel
Lytton Springs, Burgess, Clos du Val
Pinot Noir
Try the Oregon offerings!
Chardonnay and Sauvignon Blanc
Kenwood, Dry Creek, Chateau St. Jean, Matanza Creek, Sonoma-Cutrer, Mark West, Haywood

Dessert wines
Grand Cru, Firestone, Phelps, Felton empire

Excellent value wineries
Fetzer, Round Hill, Gallo, Glen Ellen, Rutherford Hill, Berringer and Boeger

French wines
Bordeaux
Chateau Pichon Longeuville Comtesse de LaLande (or their second label, Reserve de la Comtesse), Chateau Leoville Las Cases, Chateau Lunch Bages, Chateau Palmer, Chateau Figeac, Chateau LaMission, Haut Brion, Chateau L'Evangile

Bargains
Chateau Gloria, Chateau Chasse Spleen, Chateau de Grange
Burgundy
It is far more important to pay attention to the shipper than the name of the vineyard, Dr. Baumgartner recommends. Some of the shippers to try:
Bouchard Pere & Fils, Jadot, Drouhin, Dujac, Coron Pere & Fils, Bouree Fils, Labore Roi, Moillard, Bichot, Faively, Jacques Prieur
Sauternes (not to be confused with the fortunately disappearing generic white wine labeled such in the U.S.)
Chateau Rieussac, Chateau Sudiuraut, Chateau Coutet, Chateau deFargues
Sparkling Wines
Lanson Black Label (France), Piper Sonoma, Shadow Creek
— *Deborah Athy*

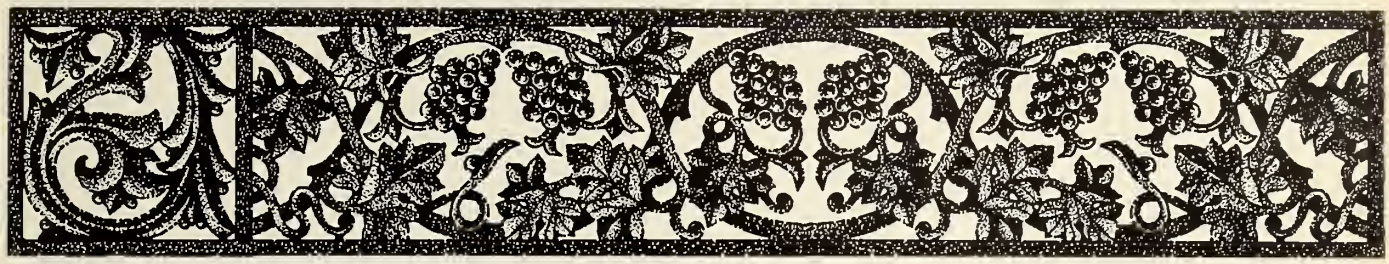
fair amount of residual sugar and not even know it."

Then, gradually, there seems to be a natural change in taste, and people begin to prefer wines which are drier. But, he hastens to add, "There's this idea that sweet wines are terrible, but that's not true. There are some really top-notch dessert wines — some of the French Sauternes are outstanding."

Some people will start a wine appreciation class saying, "I can't tell the good wine from the bad," he continues. "You can show them 'the good' from 'the bad' in a relatively short period of time," he says, but from there it's largely a matter of individual taste.

In the first couple of weeks, students learn the "taste" and "smell" of wines. Next, various ingredients — acid, tannin, sugar — will be added to water and then to a standard wine, so that students begin to recognize how these substances affect the overall taste.

A wine appreciation class is a good way of "sorting things out" — when is sweet *too* sweet, for example — and learning the appropriate winesque vocabulary. "Some phrases are meaningless," says Dr. Baumgartner, who is certified by the Society of Wine Educators, a national organization. For example, someone may say, 'This wine has good breeding.' A nebulous phrase such as this may mean something to that person, but it doesn't mean anything to me," he points out. But if a person comments on the amount of acid or sugar in a wine, then the meaning is clear, he says.



But Dr. Baumgartner admits that these obscure expressions probably come into use because "it's very difficult to describe what you're tasting and smelling."

It's sometimes difficult, too, to combine a busy medical practice and involvement in organized medicine with an avid interest in wine. "It's hard to work in the time for a class, but I enjoy it," says Dr. Baumgartner. "It's interesting to see the effects the class has on the students and the interest they develop in wine."

Dr. Baumgartner also reserves time for a private wine-testing group which has been meeting for the past 11 years. Every month, each person brings a bottle of wine — without the labels — for the group to taste and rate. This experience has taught him that, even among experts, there can be a significant variation of opinions. "That's why I like blind tastings," he says. When you don't know the name of the wine, you are just as apt to choose something inexpensive — although he admits that, unfortunately, this doesn't happen very often.

Dr. Baumgartner became interested in wines after completing his surgical residency — and finding himself with a little more time and a little more extra funds. Over the years, wine became "one of my prime interests outside of medicine," he says.

Along the way, he also tried his luck at making his own recipe. "The only wine I felt comfortable about serving was a sparkling wine made from gooseberries, not even grapes" — though you wouldn't be able to tell the difference, he assures. In fact, Dr. Baumgartner put a bottle of his gooseberry concoction in a blind-tasting with a bottle from one of the major champagne houses in France, commemorating the 1976 U.S. Bicentennial. While the group slightly favored a French bottle, the Ohio-made wine held its own, he says.

Dr. Baumgartner is a member of a number of wine groups, including the American Wine Society and Les Ami du Vin, and has gone on several jaunts with these groups — twice to the Bordeaux, Burgundy and Champagne areas of France, as well as to California's wine country.

"One of my biggest gripes in

Vintage Advice

"It's very easy for someone to go out and buy an excellent wine if money is no object," says Donavin Baumgartner, Jr., MD, OSMA president-elect and wine connoisseur. "You can recommend the Grand Cru Burgundies or First Growthes of Bordeaux, but that doesn't really help anybody."

According to Dr. Baumgartner, money is not always the end-all in wine selection. "What I like is to try to find the bargain wines," he says — admitting it's a challenge to find inexpensive wines which don't *taste* inexpensive.

"People who downgrade Gallo don't know anything about wine," he claims. While he points out that Gallo doesn't compare with the grand elites of wine, he assures "It's a very good wine for the price."

"Gallo used to have a reputation for making cheap, soda-pop wines, and then they began producing a line of "Hearty Burgundy" and "Chablis Blanc,"which contained a lot of residual sugar," Dr. Baumgartner explains. But now they've ventured into varietals (varieties which take the name of the grape from which they're made), such as Cabernet Sauvignon, Chardonnay, Zinfandel and Riesling.

"Gallo has a 1980 Cabernet that is worth twice the price they're asking . . . and there's a recently vintage dated Zinfandel (either 1981 or 1983) which is outstanding for the price."

As far as the granddaddy of wine-producers, France, is concerned, Dr. Baumgartner says many of the traditional French wines are superb. "They don't change or experiment much, but they've had hundreds of years to develop their wines," he points out.

"I have tried valiantly to like Italian wines," he continues, but he suggests that the U.S. receives a huge amount of *ordinary* Italian wines, instead of their best bottles.

Of the wines produced in California, Napa Valley reds and Sonoma Valley whites are hard to beat, he says. California continues to advance and probably will be *the* wine area of the world in the next decade, he sums up. — *Deborah Athy*

the U.S. is that Chablis means any white wine — it can be sweet and come from any grape — but Chablis from France is a very specific Chardonnay which comes only from a specific area and is actually quite dry and of a much higher quality," he explains. And such is the case with other generic wines such as Burgundy, Claret, Sherry and Rhine, which are named after familiar European wine-producing districts.

At restaurants you are often asked if you'd like Burgundy or Chablis, he continues. "I'm tempted to say, 'I wish you *did* have Burgundy," he says, "because that's not what they're talking about.' Likewise, there is also a tendency in the U.S. to do the same thing with champagne, calling any sparkling wine a champagne, he adds.

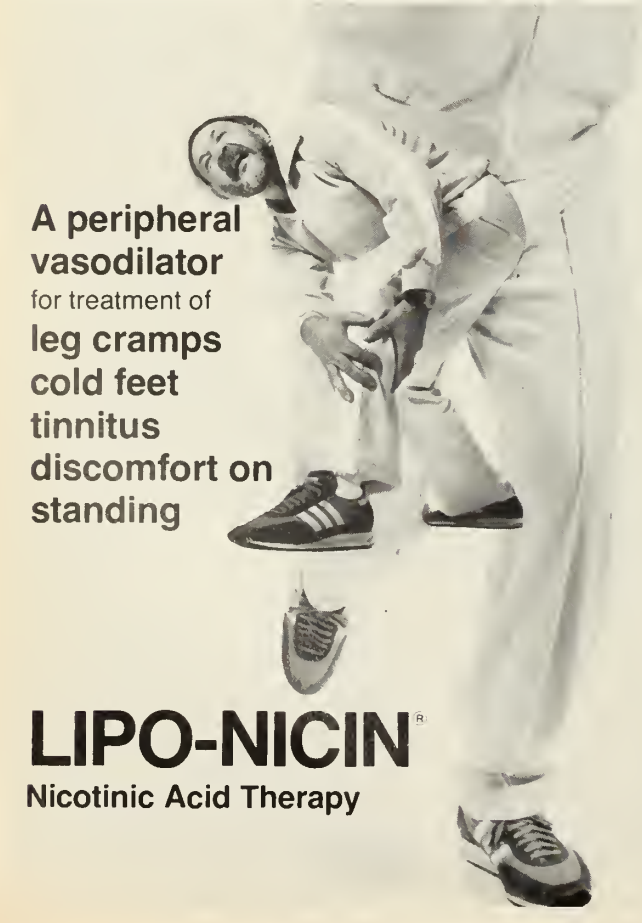
Of course, once you become fascinated with wines, the next step is to begin collecting, he says. "We built a wine cellar 17 years ago that I thought was plenty big enough. But now that the kids are grown, we've renovated half of the recreation room and now we have two." Dr. Baumgartner estimates that the two cellars house "thousands" of bottles.

He says most Ohio wine zealots probably purchase wine out-of-state to avoid Ohio's minimum mark up law. "In Chicago, Washington and New York, they discount the wines a lot, so you can buy the same wine for a fraction of what it costs in Ohio," he explains. Thus many wine collectors obtain an Ohio permit to import their wines from other states.

Another excellent and economical way to procure wine is to purchase it before it's actually bottled — a practice called *futures* — "which you base on your experience with a particular chateau and your knowledge of that year," he points out. "It's a risk in the sense you haven't tasted it. But if you're selective and if a wine has a good reputation for a certain style, you can buy very good wines at very good prices."

At present, there's a lot of good wine on the market, Dr. Baumgartner says. But if you're not sure what to bring home with you, and if you don't have enough time to take a class, Dr. Baumgartner recommends that you rely on a good wine store to assist you in your choice.

"Pretty soon, you begin to learn which wines you like and which ones you don't like — and that's the most important thing," he concludes. "It doesn't matter how many people think it's the greatest wine in the world. What tastes good to you is the most important thing." **OSMA**



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Pyridoxine HCL (B-6) .....10 mg.
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AVAILABLE: Bottles of 100, 500.

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Ascorbic Acid.....150 mg.
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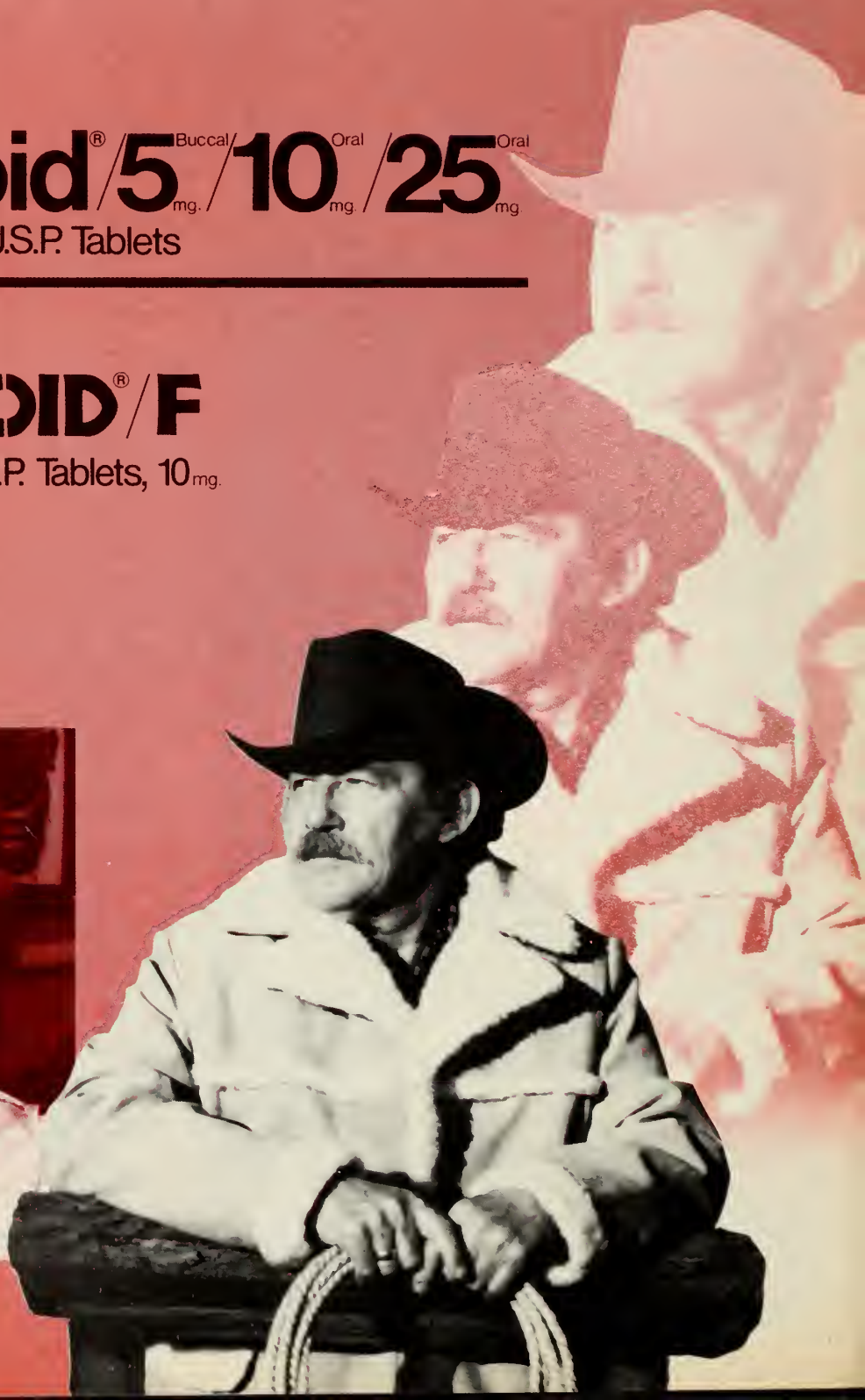
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The Peer Review Process
continued

emphasizes that — unlike a malpractice case — there is no insurance for this kind of procedure.

"The problem with the sanction process," Todd explains, "is that the first opportunity the physician has to cross-examine his or her accusers is *after* the sanction has been imposed by the OIG."

Due process has improved somewhat with the AMA's recent agreement with the OIG, however. The burden of proof — once placed on the physician, now rests with the OIG (with the assistance of the recommending PRO), and the sanctioned provider or practitioner may now request the subpoena of witnesses if he or she elects to take the case before an administrative law judge in an appeals procedure.

However, this can be a lengthy process, warns Todd, and he advises physicians to be prepared to take a lot of time off from their practices to deal with this very important matter. He cites a recent case where three full days of testimony were given in a case of a gross and flagrant violation. "It's a long and extensive process," he adds. "Substantial violations can take weeks or months to resolve."

If a physician feels he or she has still not been fairly treated (by the ALJ), the next step is to take the case before an appeals council, and a physician can appeal even further — by going to the Federal District Court — if he or she chooses to do so. "But no new evidence can be introduced at this level," says Todd — so, he advises physicians to present their best arguments at the ALJ hearings.

Still, hearings, sanctioning and appeals may all be unnecessary, reminds Dr. Briggs, if only Ohio physicians would cooperate and become involved in the peer review process. "If there is no participation," he points out, "then, indeed, it will be difficult to have *peer* review."OSMA

David Sweet is Editorial Assistant for **OHIO Medicine.**

A Presidential Profile . . . *continued*

force on cancer screening. "This area seems to be going in all different directions. I want to reinstitute the committee to provide leadership as well as an arena for developing dialogue on approved treatments. I also want the committee to try to ensure that all entrepreneurial types of cancer centers are under physician direction."

2.) Finish tort reform in an assertive fashion.

3.) Patient education. "I haven't changed — this is still my number one goal," he says. "We need to be absolutely certain that we are doing everything we can to educate patients and the public on what's happening to their health care system." *Tiered care, health care rationing* and *discount medicine* are all topics he hopes will be addressed in brochures generated by OSMA's Department of Communications. He sees these materials as a catalyst — a means of opening up discussion between doctor and patient on the issues facing medicine today. "We have to become more vocal. We have to deliver the message to our patients that their health care system is being destroyed, and here's what they can do about it."

Dr. Irons is quick to note the importance of legislative activity, and points out that each brochure handed out in a physician's office will carry information on where and how to write legislators.

"There is no hope for success without legislative organization — because the bottom line is clout. Without clout you can't accomplish anything."

But legislative clout is not the only kind of power Dr. Irons is seeking — membership clout is another area he hopes to address as president.

"Never has medicine needed (organized medicine) more, and yet never have so few done so much."

Dr. Irons hopes to get the Membership Committee involved in finding better ways to serve the "middle-aged physician." "We're doing a good job with the older and younger group of physicians, but the needs of the middle group have been apparently neglected," he says, as this group of Ohio doctors are not members in a significant percentage. And, as far as that traditional core of physician non-members is concerned, he's determined to reach out, personally, and encourage them to join.

"We need to let them know what OSMA is doing on their behalf, and what it can do for them in the future," he says.

At the House, he challenged each member there to bring in one new member.

"By gaining in strength and by mobilizing forces — at the hospital, the county, the state level — then tort reform can be ours, and we *can* prevent legislated health care," he stated.

The words — the programs are ambitious, but can Dr. Irons really hope to accomplish his goals in one short year?

S. Baird Pfahl, MD, past president of the OSMA, thinks he stands a shot at it.

"I've always thought Ross had some English blood in him because he's just like a bulldog when he's put on a project. He stays with it and wrestles with it until it's done. He proved that with the work he did on the governor's task force. He shows incredible attention to detail, and he will allocate whatever amount of time is needed to do the job. He's a voracious worker," says Dr. Pfahl.

Then, with his next remark, he cuts neatly through the "tough-guy" image of OSMA's new president.

"Ross is a compassionate individual who cares very deeply about his patients," says Dr. Pfahl. "And I always thought that was the mark of a good president."OSMA

Karen S. Edwards is Executive Editor, **OHIO Medicine.**

Next month, Dr. Irons column will begin.

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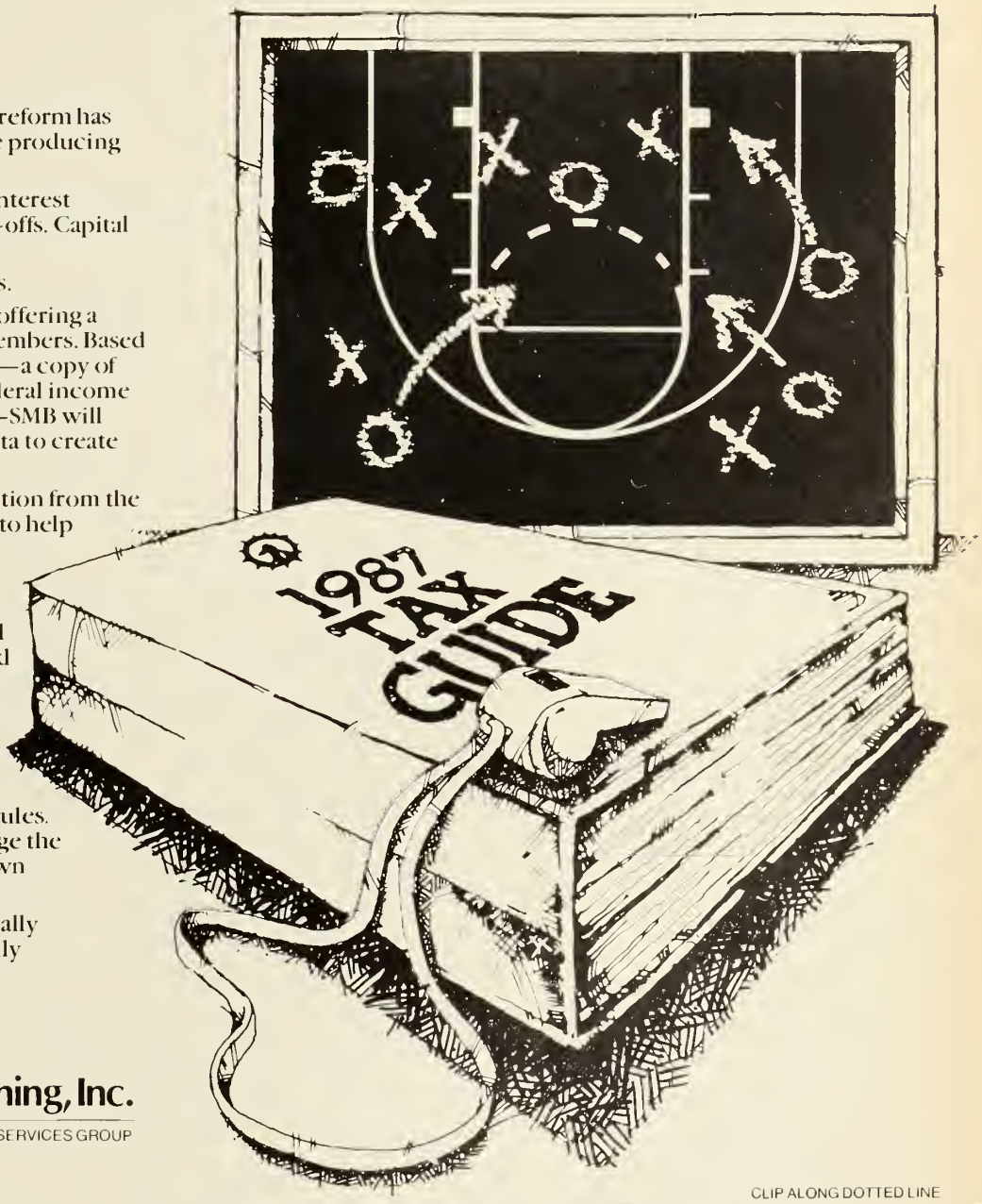
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A Practical Approach For Physicians to MAAC Issues

Richard S. Cooper and David E. Weiss

For the past several months, physicians throughout the state have been attempting to cope with the Maximum Allowable Actual Charge or "MAAC." The MAAC is the maximum fee which a nonparticipating physician may charge for a service provided to a Medicare patient. Although the MAAC law went into effect at the beginning of this year, physicians are continuing to raise numerous questions regarding the MAAC. This article will answer some of the questions most frequently asked by physicians. These questions concern the following:

- The determination of the correct MAAC;
- How a physician's charges during the April through June, 1984 quarter affect the MAAC calculation;
- The procedure to obtain a calculation or recalculation of a MAAC; and
- How to respond to audit notices.

MAAC REPORTS

Q. I have received many different reports from Nationwide, how do I determine my MAAC for a particular service?

A. To determine your MAAC for a particular service, you may calculate it yourself or identify the appropriate MAAC from a series of reports, each of which is entitled "MAAC Charge Report."

EXPLANATION

At the time the MAAC law went into effect, Nationwide was not able to calculate a MAAC for each service provided by a physician. Most physicians received a package of reports at the end of 1986 or the beginning of 1987. These reports included: (1) a Level I Detail Report or Base Period Charge Report, (2) a Level II Detail Report or MAAC 50th Report, (3) a Prevailing Charge Report, and (4) a Customary Charge Report. The first three reports and an instruction sheet, available from Nationwide, are necessary to calculate a physician's MAAC for each service, i.e., CPT code.

In early 1987, Nationwide began calculating some of the MAACs for physicians. Consequently, Nationwide distributed a second set of reports; each report entitled "MAAC Charge Report." Physicians can determine their MAACs based upon these reports rather than calculating their MAACs using the earlier reports distributed by Nationwide. Although all of the more recent reports are entitled "MAAC Charge Report," a physician must review these reports in the proper sequence, described in the steps below, to determine the correct MAAC for a particular CPT code.

STEP 1

The first MAAC Charge Report which should be reviewed by a physician is the individual MAAC Charge Report, a report containing data specific to the physician. This report sets forth the physician's locality (the figure following the abbreviation "LOC"), the physician's specialty (the figure following the abbreviation "SPEC"), *and* the physician's (or professional corporation's or partnership's) provider number. For most physicians, this individual MAAC Charge Report will list only some of the physician's CPT codes. (The relatively small number of MAACs on this report does not indicate that a physician lacks additional MAACs. MAACs for other CPT codes may be calculated by the physician using the first set of reports distributed by Nationwide, or by reviewing the other MAAC Charge Reports. It should be noted, however, that if a physician chooses to rely on a MAAC found on the other MAAC Charge Reports, then this MAAC will not be based on the physician's own charge history. Only MAACs found on the *individual* MAAC Charge Report or those calculated by a physician are based on data specific to that physician.) If no MAAC is found on this report for a particular CPT code, only then should a physician review the other MAAC Charge Reports described in steps 2 through 5.

STEP 2
The next MAAC Charge Report which should be utilized sets forth the physician's locality and specialty but *not* the provider number. Unlike the MAAC Charge Report described in Step 1, which is specific to the physician, this second MAAC Charge Report is based on data for all physicians in the same locality who practice in the same specialty. A physician should use the MAAC listed for a CPT code found on this report only if a MAAC is not listed on the individual MAAC Charge Report described in Step 1.

STEP 3
If no MAAC for a CPT code is found on either of the reports described in Steps 1 and 2, a physician must examine a third MAAC Charge Report. This MAAC Charge Report will not have a locality identified. Therefore, a "00" will follow the abbreviation for locality at the top of the report. Also, as is the case with the MAAC Charge Report described in Step 2, no provider number will be found on this report. However, this report will identify the physician's specialty. This MAAC Charge Report provides MAACs based on charges of physicians in the same specialty who are practicing in all of the carrier's localities.

STEP 4
If a physician cannot find a MAAC for a particular CPT code on any of the reports described in Steps 1 through 3, the next MAAC Charge Report must be utilized. This MAAC Charge Report can be identified by a "00" following the specialty abbreviation with a specific figure identifying the physician's locality. This report provides MAACs based on data for all physicians in the particular locality regardless of specialty. It should be noted that for the most part, physicians will not need to review this report because a MAAC for a CPT code can be found under the previous steps. Therefore, Nationwide may not have distributed this report. However, if a physician needs to review this report and it has not been provided, a physician may obtain this report from Nationwide at the following address: Nationwide Mutual Insurance Company, Medicare Health Insurance, PO Box 57, Columbus, Ohio 43216, Attention Disclosure Unit. This request should specifically identify the report sought and include the physician's name and provider number.

STEP 5
If no MAAC for a CPT code is found on the reports described in Steps 1 through 4, the final MAAC Charge Report must be used. This MAAC Charge Report will have a "00" following both the locality and specialty abbreviations. This report is not specialty-specific and is based upon data from all carrier localities. Because this report is rarely used, it also may have been omitted from the package sent by Nationwide. However, if needed, a physician may obtain this report from Nationwide.

STEP 6
According to the Health Care Financing Administration, which administers the Medicare program, if no MAAC is found for a CPT code on any of the MAAC Charge Reports, the MAAC restrictions do not apply to that particular service.

Because a physician's individual MAAC Charge Report contains a limited number of MAACs and those which are listed should be verified, it is recommended that physicians calculate at least some of their MAACs. In particular, CPT codes with high dollar values or high volume CPT codes should be confirmed by a separate calculation of the MAAC by the physician. If a physician calculates a MAAC not found on the individual MAAC Charge Report described in Step 1 above, or if the MAAC which a physician has calculated for a CPT code is different from the MAAC calculated by Nationwide for such CPT code, or if a physician identifies an incorrect MAAC, the physician should contact Nationwide (see "REQUEST FOR CALCULATION OR RECALCULATION OF A MAAC").

BASE PERIOD CHARGES

Q. What is a base period charge and how is it utilized in calculating the MAAC?

A. Generally, the base period charge for a service is the median of charges to Medicare patients for such service for the period April through June, 1984. If a physician has a base period charge, this charge serves as the basis for calculating the physician's 1987 MAAC.

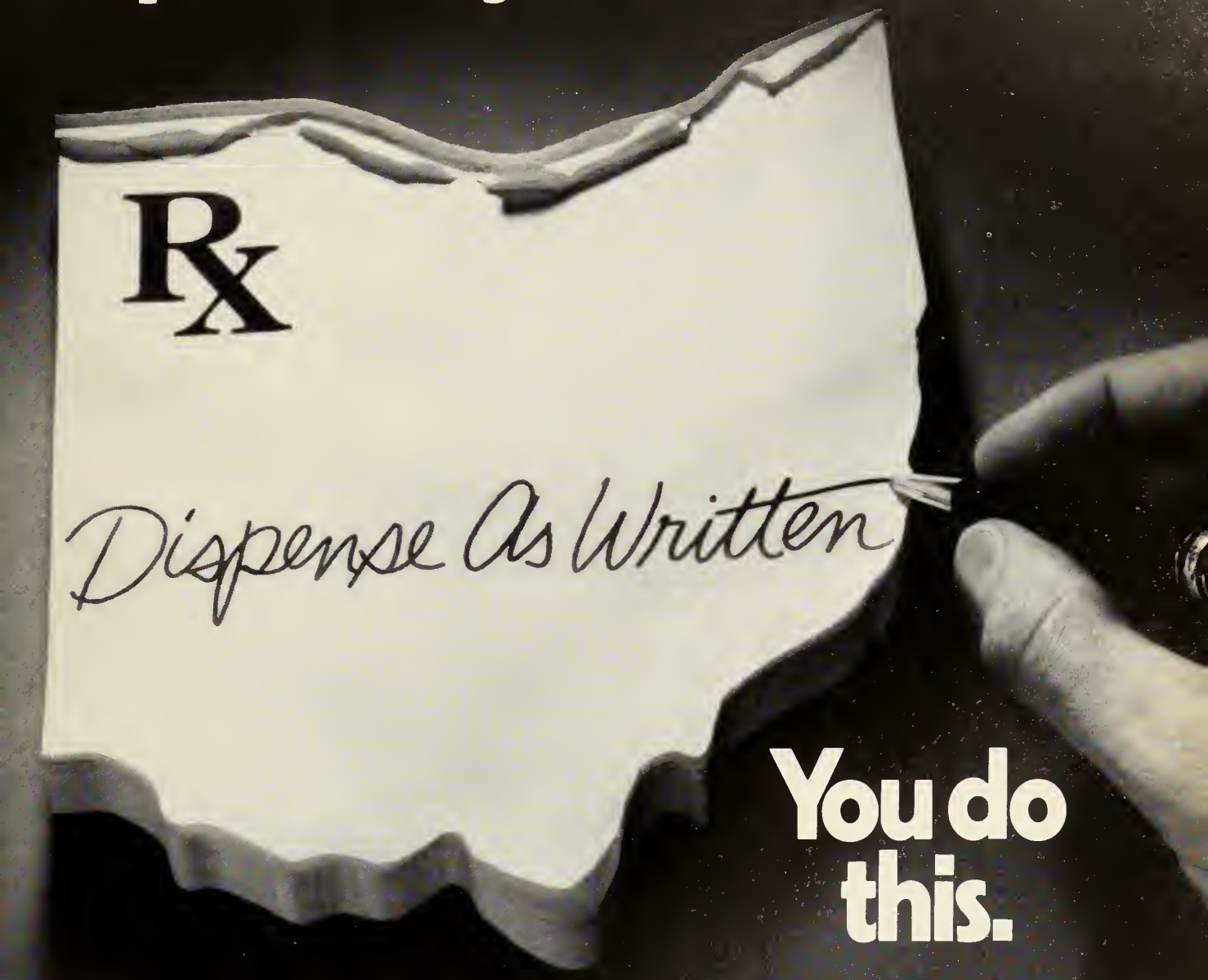
EXPLANATION

The MAAC law requires that if a physician has a base period charge for a service, then this charge should be utilized in calculating the MAAC for such service. If a physician did not provide a particular service during the April through June, 1984 quarter, an alternative figure is used as the basis for the MAAC calculation. This alternative figure is the median of charges for the service by all nonparticipating physicians in the same locality and specialty during the charge year ending June 30, 1986. This figure is sometimes referred to as the "MAAC 50th." To determine which of these two figures Nationwide used in calculating a MAAC, a physician can review his or her individual MAAC Charge Report. If no asterisk appears after the MAAC figure, then a base period charge was used; if an asterisk follows the MAAC figure, then the MAAC 50th was utilized.

The MAAC law was initially interpreted to require three charges during the base period quarter for a physician to establish a base period charge. Consequently, Nationwide's computer was programmed to provide MAACs based upon a base period charge only if their records revealed three claims submitted by a physician for a service rendered during the base period quarter. However, as the MAAC law is currently being interpreted, if a physician has one charge for a service rendered during the April through June, 1984 quarter, then this charge may be used as the physician's base

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period charge or if two charges are found, then the higher of the two charges may be used as the physician's base period charge. Because of the original interpretation of the MAAC law, certain MAACs listed on a physician's individual MAAC Charge Report will be followed by an asterisk although the physician, in fact, has one or two base period charges. The physician may request a recalculation of the MAAC pursuant to the procedure described below.

REQUEST FOR CALCULATION OR RECALCULATION OF A MAAC

Q. If I identify an incorrect MAAC on my individual MAAC charge report, or I calculate a MAAC which is not present on my individual MAAC charge report, how can I establish a new MAAC?

A. A physician may contact Nationwide with supporting evidence and request that Nationwide calculate or recalculate a physician's MAAC for a particular CPT code.

EXPLANATION

If a physician has a MAAC followed by an asterisk on the individual MAAC Charge Report but has a base period charge or if the stated MAAC is otherwise incorrect, a recalculated MAAC can be established by supplying the necessary evidence to Nationwide. Furthermore, if a physician calculates a MAAC not listed on the individual MAAC Charge Report, a physician may contact Nationwide to verify the MAAC. In all instances, however, a physician must provide some evidence of the existence of charges to Nationwide during the base period. The evidence of a charge must include the following information:

(1) The patient name or beneficiary name;
(2) The patient health care number or HIC number;
(3) The date of service (April through June, 1984);
(4) The code for or a description of the service in question;
(5) The fee for the service; and
(6) The name of the physician who rendered the service.

The best evidence of a charge is a photocopy of a health insurance claim form containing this information. However, the claim form is not the only evidence which Nationwide will accept. Any other "reasonable" evidence of a charge is sufficient. Reasonable evidence includes, but is not limited to, a copy of office records. This information may also be provided to Nationwide in narrative form. A physician should attempt to submit evidence of three charges for each CPT code. However, if a physician is unable to do so, a physician should submit whatever charge data is available for the service provided during the base period. All communications regarding the calculation or recalculation of a MAAC should be sent to:

Nationwide Mutual Insurance Company
Medicare Operations
Audit & Analysis Division (13-T)
Attn: MAAC
PO Box 57
Columbus, OH 43216

Due to the overwhelming number of requests for calculations and recalculations received by Nationwide, requests for MAAC calculations or recalculations should, at present, focus on a physician's high dollar value CPT codes or high volume CPT codes. Furthermore, before requesting a recalculation by Nationwide, physicians should

verify that a problem exists by calculating the MAAC themselves for comparison with the MAAC calculated by Nationwide. Hopefully, if MAAC calculation or recalculation requests are limited in this manner, Nationwide's response time will not increase beyond the current period, which Nationwide has indicated is approximately four to eight weeks.

AUDIT NOTICES

Q. If I receive an audit notice concerning a CPT code for which I have obtained a recalculated MAAC from Nationwide, how should I respond?

A. A copy of the letter from Nationwide acknowledging the recalculated MAAC should be attached to a copy of the audit notice and returned *promptly* to the Enforcement Division of Nationwide. You may wish to contact your legal counsel to determine if additional action is advisable.

EXPLANATION

When Nationwide originally distributed a physician's MAAC Charge Reports, this information was forwarded to the Enforcement Division of Nationwide. The Enforcement Division will monitor a physician's claims based upon the MAACs as calculated by Nationwide. However, not all recalculated MAACs may have been entered into the Nationwide computer system at the time a physician's charges are reviewed. Therefore, because the Enforcement Division may be monitoring a physician's claims based upon the original MAAC calculations, an audit notice may be issued automatically if a recalculated MAAC is greater than the original MAAC. This situation can be remedied by the physician sending a copy of the Nationwide letter acknowledging the recalculated MAAC along with a copy of the audit notice to the Enforcement Division of Nationwide. **OSMA**

Richard S. Cooper, Esq. and David E. Weiss, Esq. are attorneys with the Cleveland law firm of McDonald, Hopkins & Hardy Co., LPA McDonald, Hopkins & Hardy Co., LPA is a general practice law firm. The firm represents a substantial number of physicians and health care entities in areas such as entity formation and governance, compensation planning, tax planning, retirement plans and fringe benefits, third-party payor reimbursement, health care contracting, regulatory compliance, estate and succession planning, and general business consultation.

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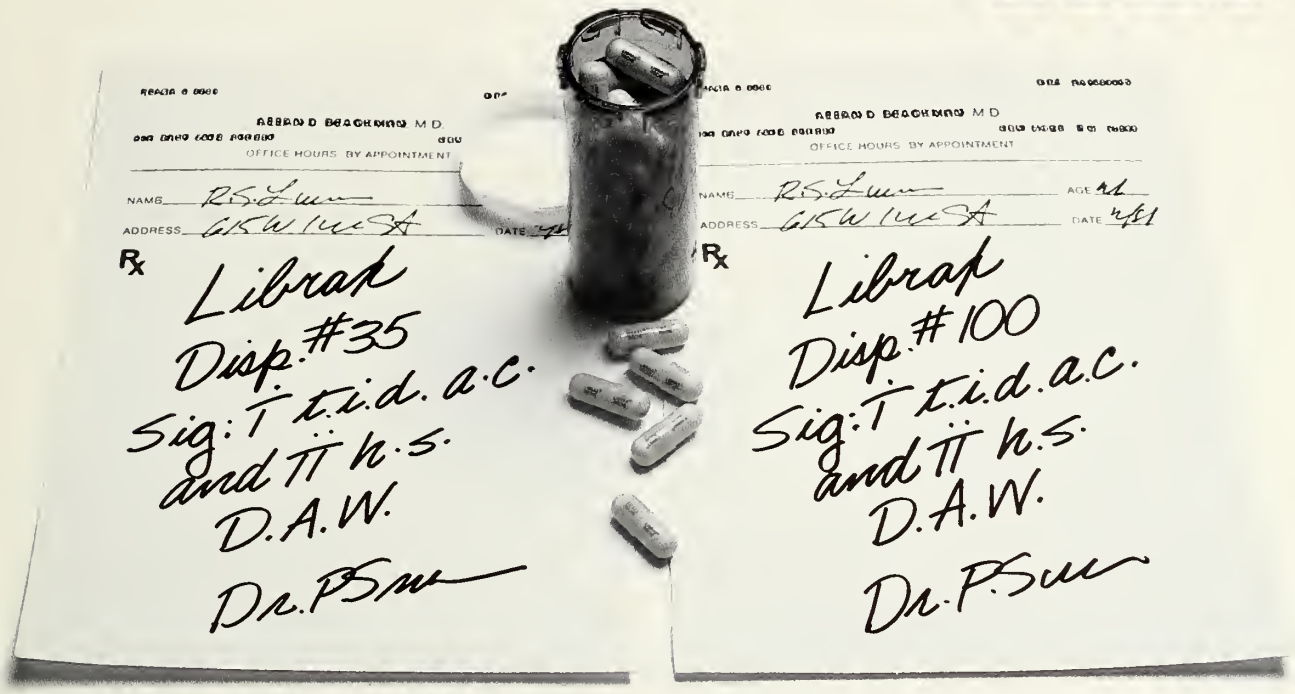
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14th ANNUAL "PEDIATRICS FOR THE PRACTICING PHYSICIAN" Symposium. October 9-10, 1987, Radisson Hotel, Toledo, Ohio. Sponsors — Medical College of Ohio and Affiliated Hospitals, Northwest Ohio Pediatric Society, & Ohio Chapter American Academy of Pediatrics. 11 Hours of Category I; Fee — $165.00. Contact: Molly T. Vogt, Ph.D., Medical College of Ohio, Continuing Med. Education, 3000 Arlington Avenue, Toledo, Ohio 43614, (419) 381-4237.

Specify Adjunctive **LIBRAX®**



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/ Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

PI 0186

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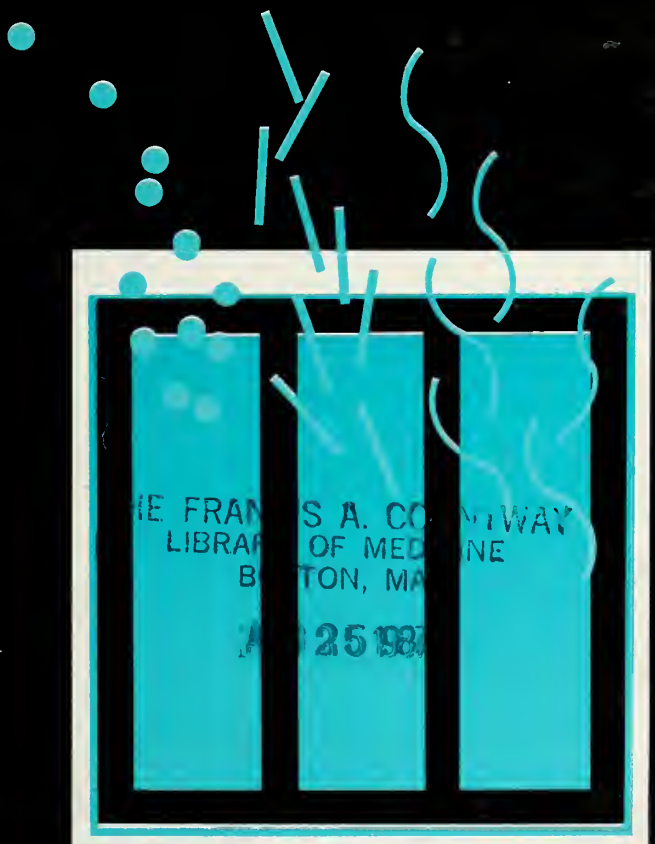
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JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 83, NO. 8 AUGUST, 1987

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CLINICAL UPDATE

OHIO STATE MEDICAL ASSOCIATION

Clinical Update
and Exposition

September 18, 19 & 20, 1987

Hyatt Regency Columbus
at Ohio Center

The rewards of Limbitrol
You're both smiling again!



See the difference in the first week[1]

In depressed and anxious patients, you can see the difference sooner—62% of total four-week improvement achieved in the first week with Limbitrol versus 44% with amitriptyline.[1]

In moderate depression and anxiety

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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

ROCHE

Please see summary of product information on adjacent page.

See the difference in the first week[1]

- **Sleep improvement in 74% of patients after first h.s. dose[2]**
- **Significantly faster relief–62% of total four-week improvement evident in first week versus 44% with amitriptyline alone[1]**
- **Dramatic first-week reduction in somatic complaints[2]**

% Reduction in Somatic Symptoms[2]



- **Only ⅓ the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar[1]**

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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Protect your decision.
Write "Do not substitute."

In moderate depression and anxiety

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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

References: 1. Feighner JP, *et al. Psychopharmacology 61*:217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

Limbitrol® Ⓒ IV
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500, Tel-E-Dose™ packages of 100, Prescription Paks of 50.

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Published monthly under the direction of The Council for and by members of OHIO Medicine, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1987 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: OHIO Medicine, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

OHIO Medicine does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

FROM THE EDITOR

OSMA's Scientific Meeting — Its New Time May Mean New Recognition

This year marks the first time that the Ohio State Medical Association will hold its Scientific Meeting in the fall, instead of immediately following the association's annual spring business meeting.

The schedule change, however, has been a long time coming. Officials at the OSMA have recognized for some time that it is difficult for members to schedule a week of time off from busy practices to attend meetings — which is the reason why, several years ago, the OSMA compressed its regular Annual Meeting activities into the space of a weekend. However, while that move has worked well — fewer and fewer members were staying after the meeting to attend the excellent clinical programs offered by various specialty groups . . . and even fewer were coming in to attend these programs.

The change, then, is an attempt to bolster the Scientific Meeting's sagging attendance figures — one, by placing it on days when most physicians can reasonably break away; and two, by calling special attention to itself. After all, the Scientific Meeting has existed the past few years as something of an afterthought. Now, it stands apart — on its own merits and in its own right — as a meeting well worth your time and attention. You'll find all the information you need about this year's programs included in this issue. Take a look through our special section and make plans *now* to attend. You're sure to find this year's Scientific Meeting both bigger and better than ever.

This issue also carries the official minutes of the OSMA House of Delegates and next month we'll feature brief write-ups on those Councilors who were elected — or re-elected — by the House. This is a good opportunity for some of you to learn a little more about the men and women who are representing you and your interests in organized medicine.

You'll also want to read this month's Presidential Perspectives — in which OSMA's new President, D. Ross Irons, MD, reveals his thoughts, goals and dreams for the year ahead.

This month also marks the return of the "Ask the Ombudsman" column. This column, co-authored by William Fry and Janet Shaw of the OSMA's Department of Professional Relations, is here to help *you.* If you have a problem — or question — for the column, write it down and send it in. You'll not only be helping yourself, but probably others, just like you, who may have a similar problem and are wondering what to do.

Next month, *OHIO Medicine* will take a look at medical education — and how it is likely to be structured by the 21st-century. We will also include a profile of the state's new Director of Health, Ronald Fletcher, MD.

Karen S. Edwards

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USPS 405-200

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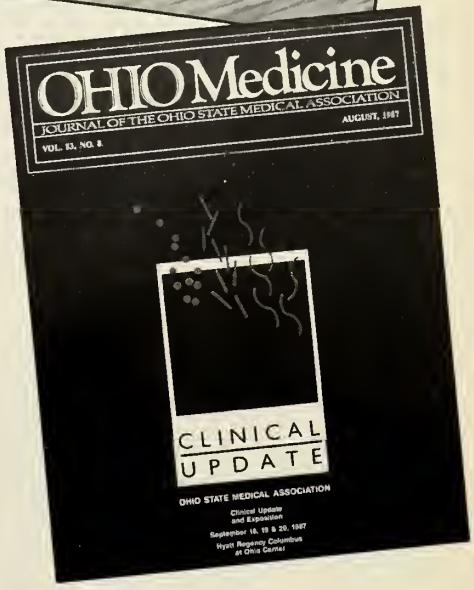
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J-6138 January 1986



An Open Letter to the Members of OSMA

At the Annual Meeting of the Ohio State Medical Association, immediately following my induction as your president, it was my privilege to address the House. At that time, I attempted to share with those in attendance the "focus" for the year, as I perceived it to be. In addition, I had hoped to share with those in attendance, an outline of the tasks facing you and me in the coming years. At that time, I felt somewhat frustrated because not only was I addressing only a small segment of our association, but also, that segment was already "involved" as evidenced by their presence and participation in the Annual Meeting. Now, via this open letter to the membership, I am most pleased that I can share with you an overview of that address and delineate "the focus" of the Ohio State Medical Association for the coming year.

For the past several years, I have heard lots of "doom and gloom" in the halls of medicine. More recently, many have questioned my good sense as I assumed the office of president at this particular time, when it would appear medicine's struggle on behalf of the patient seems shrouded with adversity. I, however, am not depressed by this situation, but am, instead, stimulated by the challenge, and the opportunity to possibly be a positive factor in the shaping of Ohio's health care delivery system at this most critical point in time.

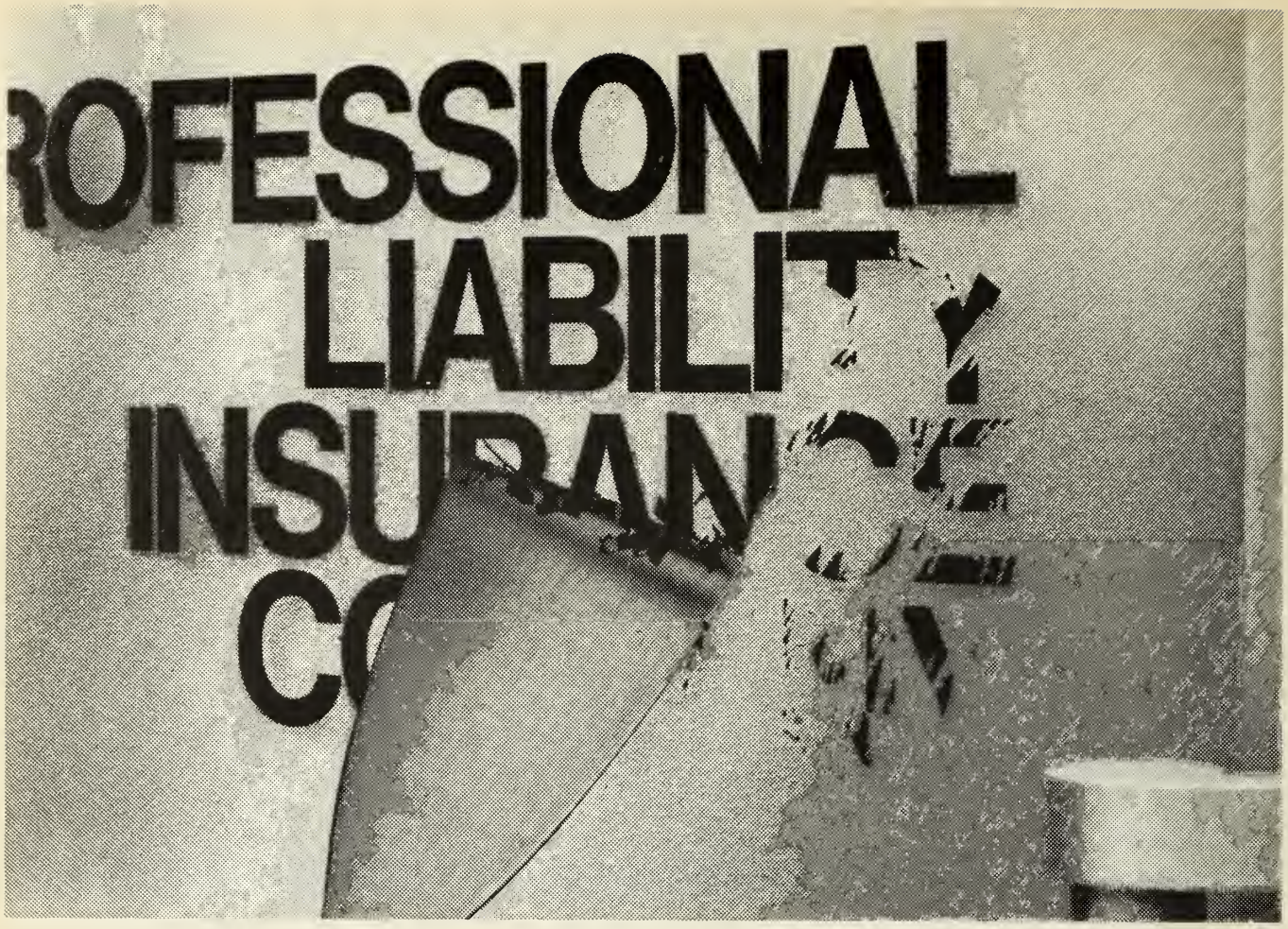
The theme of the AMA's leadership conference last spring was "Taking Charge in a Time of Change." My version, and hopefully the focus of the Ohio State Medical Association during the next year will be "Taking Charge for a Change." I realize that this is a play on words, but I think it is "bottom-line" when one considers the current status of our health care delivery system. It has been my observation (and, I am sure, that of many) that everyone *except* the physician and the patient seems to be involved in the health care development and decision process. Examples would be: the insurance companies negotiating physicians' fees without physician input or negotiating patient access without patients' knowledge or contribution; legislative bodies and entrepreneurs engaging in health care rationing in the name of cost containment; hospitals and corporations practicing medicine without a license. Therefore, the number one focus appears to me to be the REINSERTION OF THE PHYSICIAN AND PATIENT BACK INTO THE FORMULA.

Now, if we aggressively seek fair and equitable representation in the health care arena, then we must also be willing to stand and be counted — that is, to endure some "short-term pain for long-term gain," an often quoted definition of progress.

Focus number two, then, should be on places where we *can* stand and be counted, for example, physician peer review, insurance risk management, etc. We also need to focus on ourselves. When physicians review a proposed contract or deal which might be financially rewarding to their practice, but not in the best interest of patient care, we should have the intestinal fortitude to say no.

The suggested third focus for the coming year is a Positive Proactive Program and Attitude — a logical development if we wholeheartedly believe we can extract ourselves from this

continued on page 503



In ten years your malpractice carrier may be just a memory.

Unless it's Medical Protective.

As you consider professional liability insurance, consider this. The coverages stated in the policy are basically a promise — a promise to be here when needed regardless of legal climate or economic conditions. A company's ability to keep this promise is critical because your financial security may depend on it. Unfortunately, too many firms are now finding the task impossible.

Analyze your liability insurance options carefully just as you would any important investment. Go beyond the agent and the policy to the company that stands behind both. How long has it been in operation? Has it weathered some of the tough times? Will it be there for you when you need help?

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To be successful in the legislative arena, organized medicine must have clout . . . To have clout, we must have a unified, aggressive association at all levels.

condition of "agitated apathy." An excellent example of this is the OPEN program, recently initiated by the Ohio State Medical Association. This program, if widely instituted, might possibly head off the proposed mandated assignments one hears mentioned in the legislative halls.

To be successful in the legislative arena, organized medicine must have clout. More and more health care decisions are being made according to legislative rule. To have clout, we must have a unified, aggressive association at all levels.

Focus number four — cooperative mobilization of Ohio's physicians — not only at the state and county level, but more importantly at the hospital and individual level — with the focus on LEGISLATIVE INVOLVEMENT. If we were successful in achieving this goal, then we could have meaningful tort reform, as well as the prevention of further legislative medical practice.

For the patient and the public to make intelligent, meaningful decisions, they must have basic information within their grasp. It will take the majority of a patient population — informed as to what is currently happening to their health care system — to exert the necessary pressures in the legislative arena and the marketplace — not only to prevent further health care rationing, but also to preserve the patient's freedom of choice as to physician and hospital.

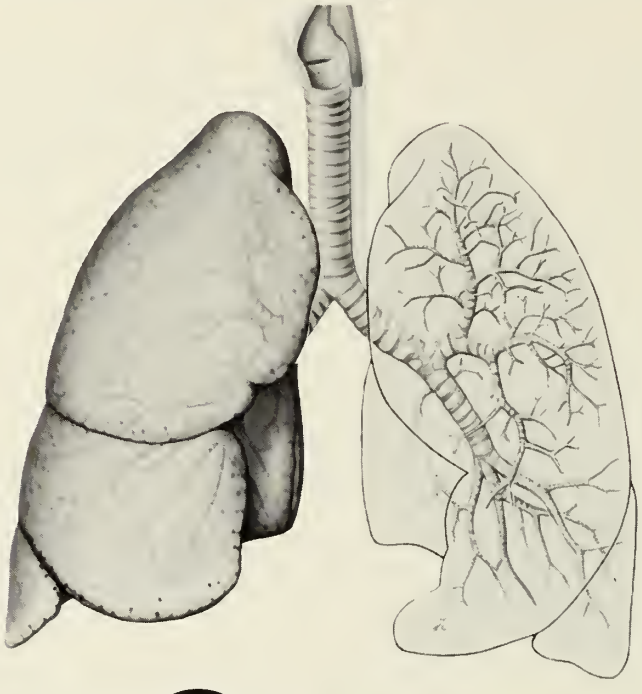
Focus number six will be to redouble our efforts in patient information and education. To that end, the OSMA will continue to do its outstanding work in this arena, and, by the end of this year, it is hoped that a booklet, presenting current and/or significant health care questions, will be ready for you to use in one-to-one discussions with your patients. Such discussions — particularly for the over 65s — will allow your patients to communicate more effectively with their state and federal legislators — hopefully creating a beneficial effect on the final outcome.

It seems almost weekly that some new health plan — HMOs, PPOs, etc. — is presented to the physician. As the plans become more complicated, physicians find they must ask themselves a great many more questions prior to signing on the dotted line. Questions such as "should physicians put themselves at risk for the purpose of lowering health care costs?" should be asked. After all, what other provider in the financial world puts himself or herself at risk for the user or purchaser? Focus number seven, then — the Ohio State Medical Association will continue to make itself available to evaluate major contracts on behalf of Ohio's physicians.

So, on behalf of the Council and the staff of the Ohio State Medical Association, let me assure you that we will be in a positive and proactive mode when dealing with the opportunities and the challenges ahead. I WOULD ASK YOU, will you likewise accept these challenges? Will you "Take Charge for a Change?" Will you seize this opportunity? I, and our patients, sincerely hope so. I firmly believe that we *MUST* Take Charge At This Time for the Right Change.

— D. Ross Irons, MD

Consider the causative organisms...



Ceclor®
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250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, Streptococcus pneumoniae
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lnwer respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci)

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other eosinophilia, 2%, genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine
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LETTERS TO THE EDITOR

The necessity of cataract surgery

To the Editor:

Although I think Dr. Greentree's goals in monitoring health care reimbursements are noble, I think the statements regarding unnecessary cataract surgery require reply. (*OHIO Medicine,* April, 1987)

It should not come as a particular surprise that 1.2 million cataracts were done in this country in 1985, if one understands the demographics of our aging society. He should be aware that the over-65 age group is a rapidly growing segment of our society, and some studies show that the over-80 age group is relatively the fastest growing. As cataract formation is part of the normal aging process, it is to be expected that many more adults are now living long enough to develop them.

Not surprisingly, the over-65 population wishes to be as active and independent as possible. It is difficult for me to conceive that "23 to 36%" of cataract procedures are "unnecessary." Unnecessary by whose standards?

In the state of Ohio, as in many states, corrected vision must be 20/40 or better to obtain an unrestricted driver's license, and must be 20/70 or better to obtain a daylight driver's license. It is a devastating loss of independence for an elderly person to lose his driving privilege because of diminished visual acuity, especially if he lives alone or in a rural region.

Cataract surgery is indeed an elective procedure. The patient elects to undergo a procedure that is 95% successful in restoring his visual loss due to cataracts. We do not drag our patients kicking and screaming into the operating room; they are there because they have decided they want to undergo this procedure in hope that it will improve the quality of their remaining years.

I was appalled to read Dr. Greentree's statement that "cataract surgery should be reserved for patients whose useful life can be improved." Useful by whose standards? I will close with a question from the family of a patient who no doubt would have fallen outside these criteria.

"On behalf of our mother, I can only say, you took a 98-year-old lady who couldn't see to read and gave her sight back to her. Her quality of life, the happy smile on her face, her renewed interest in life, say it all!"

Yours truly,
Charles L. Smith, MD
Perrysburg, Ohio

Medicare payments and profits

To the Editor:

We are very concerned when a report was recently issued that indicated hospitals were making large profits on Medicare payments. This is *not* the case, and we hope this letter will serve to clear up some of the confusion that surrounds the issue of Medicare and hospital profits.

As an illustration of the conflicting information available about this issue, consider these two statements:

"1985 hospital profit rates from PPS (Medicare Prospective Payment System) average 15.27%, up from 14.18% in 1984."

"The 1985 average net profit of community hospitals was 5.13% of gross patient revenue and virtually the entire net profit came from non-patient revenues such as investment income and contributions."

The first quote comes from the Office of the Inspector General, Department of Health & Human Services and is based on a survey of the Medicare reports of *233* hospitals.

The second quote, based on the American Hospital Association's annual survey of *5,372* hospitals, is supported by the Healthcare Financial Management Association — the independent financial body of the health care industry.

Why the huge disparity in numbers? An industry observer stated recently: "The Inspector General and the Medicare program do their number crunching in ways that no self-respecting Big Eight accounting firm would dare to use." And, to get a completely impartial evaluation of the Medicare profits, we asked the accounting firm of Arthur Andersen to study the facts. Healthcare Practice makes some interesting points:

First, Medicare decrees that certain hospital costs — including research, indigent care, and various patient and community services — are "not allowable" under its payment system. Therefore, when the Office of the Inspector General made its report, it ignored all of those "unallowable" albeit real costs, thereby understating the true cost of patient care. The result, of course, is that the baseline numbers — from which it makes all of its conclusions of "excess profit" — are incorrect and grossly understated. There also is a substantial bias in the 233 "sample" hospitals chosen for the Inspector General's report. Likewise, the size of the sample limits the validity of the findings.

continued on page 506

The fact is, hospitals in Greater Cleveland — as well as those across the country — pretty much break even on patient care. In fact, when all costs and payments are taken into account, hospitals in northeastern Ohio had 1985 net profits of 5.13% of gross patient revenue, almost all of which came from non-patient sources.

Obviously, if one uses faulty logic and leaves several real costs out of the calculations, one is able to skew the numbers to prove whatever one wants to. This is exactly the case with the Inspector General's report, according to the Arthur Andersen findings. Our contention, that the issue of Medicare "profits" is being used as a smoke screen for a skillful attack on our hospitals, can only be strengthened when such shortcomings are brought to light.

If I can provide additional information about Medicare payments and how they affect profits, or answer any other questions about health care in northeastern Ohio, please feel free to contact me.

C. Wayne Rice
President
Center for Health Affairs
Cleveland

Address your "Letter to the Editor" to: OSMA, 600 S. High St., Columbus, Ohio 43215.

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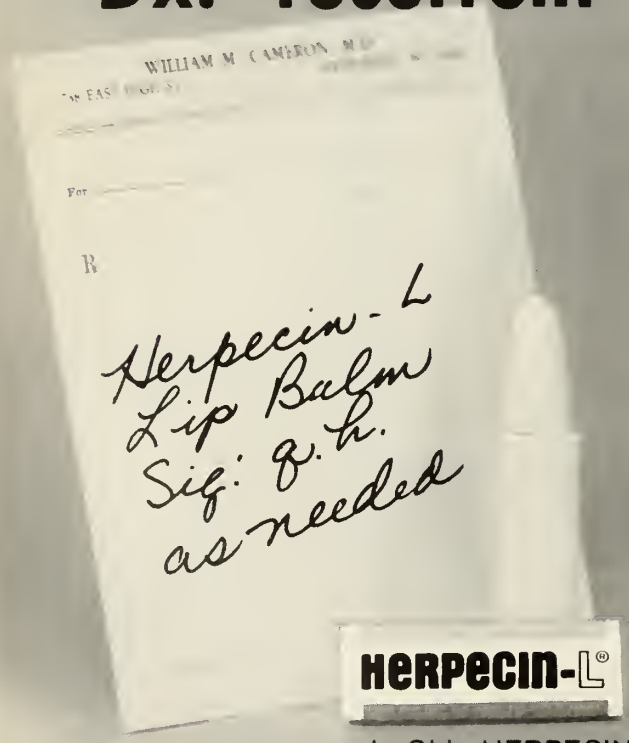
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Let the Debate Begin...

By David J. Utlak, MD

Editor's note: *This "Second Opinion" has been taken from a farewell address that President David J. Utlak, MD, presented to members of the Canton Academy of Medicine.*

How do you defeat any enemy whether it be on the field of battle or in an ideological struggle? You divide and conquer and you play up to the vices of your enemy. We have allowed ourselves to be manipulated and divided. My friends, there will always be jealousy, envy and competition amongst us. There will be division between old and young physicians, specialist and generalist, academically-trained and community-trained physicians, successful physicians and not-so-successful physicians, and competent and incompetent physicians. These divisions are inherent in the nature of man. The vicissitudes of man exist universally in any profession or endeavor. But we must speak of something on a higher plane here; and that is, the profession. We are all physicians and it must be from a united front that we respond to all these attacks.

There are other physicians who have told me that we can do nothing and that to speak of these things is idle talk and useless. Not only is this despicable but it is not worthy of a once proud profession. Furthermore, that attitude plays directly into the hands of our enemies, who know that they must break our spirit before they can break anything else. The campaign to have us believe in the inevitability of all of these changes is a key instrument in their battle.

It is natural for man to indulge in the illusions of hope. We are apt to shut our eyes against painful truths. We are apt to accept a regulation here or there and hope it will be the last. The history of the last 20 years shows us the opposite. Let's go back to 1965, when Medicare was passed. In the original act that created Medicare, Congress disavowed any intention of controlling medicine; "nothing in this title shall . . . authorize any federal officer or employee to exercise any supervision or control over the practice of medicine . . . or the compensation of any . . . employee of any institution . . . providing medical services." Now listen to a prediction from 1963 written by Ayn Rand. I quote — "Medicare is an example of such a project. Isn't it desirable that the aged should have medical care in times of illness?" its advocates clamor. Considered out of context, the answer would be: yes, it is desirable. Who would have a reason to say no? It is at this point that the mental processes of the collectivist brain are cut off; the rest is fog. Only the desire remains in his sight — it's the good, isn't it? — it's not for myself, it's for others, it's for the public, for a helpless, ailing public . . . The fog hides such facts as the enslavement and, therefore, the destruction of medical science, the regimentation and disintegration of all medical practice, and the sacrifice of the professional integrity, the freedom, the careers, the ambitions, the achievements, the happiness and the lives of the very men who are to provide that "desirable goal" — the doctors." How prophetic from 1963. In another quote from the same author in 1962, "there can be no compromise between freedom and government controls; to accept 'just a few controls' is to surrender the principle of inalienable individual rights and to substitute for it the principle of the government's unlimited, arbitrary power, thus delivering oneself into gradual enslavement."

My fellow physicians tell me we are weak, unable to cope with so formidable an adversary. But when shall we be stronger? Next week, next month, next year? Shall we acquire the means of effectual resistance by lying supinely on our backs and hugging the delusive phantom of hope? Five hundred thousand physicians who are even

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Minoxidil for baldness

The verdict is still not in on *minoxidil,* the experimental topical drug for baldness, according to a study in the *Archives of Dermatology.*

In a survey of the American Academy of Dermatologists, researchers from Beth Israel Hospital and the Harvard Medical School found 70% of the dermatologists surveyed had prescribed the drug for hair loss, though only 10% accounted for more than half of all reported prescriptions.

The overwhelming number of dermatologists prescribed it to fewer than one patient per week,



which, according to the study, "may reflect either skepticism about the effectiveness of the drug or concern about its cost."

Your job may be killing you . . .

Many people think that doctors should be healthier than average, because of their advanced medical training. But, according to a recent study, this isn't necessarily the case.

A Finnish study in *The Lancet* compared the mortality rates of physicians to those of other professionals and the general public from 1971 to 1980. Some of the findings:

- Male doctors had a significantly lower mortality rate than that of all active men, but substantially lower than the rate for other professionals. Only managers, judges and lawyers equaled the physicians' mortality rate.
- Physician death from cardiac problems was lower than the general public, but comparable to other professionals.
- Doctors had the lowest occurrence of cancer deaths compared to all other professionals.
- Physicians had a suicide rate double that of the general public. Only legal professionals had a higher rate.

Researchers think that doctors "may have some special occupational risks, which raise their mortality" rates. High stress levels, alcohol and drug abuse, suicide and possible harmful exposure to radiation or anesthetic gases are some of the possible causes, the researchers speculate.

And now, in our formal attire category

Pediatricians . . . are you dressed for success? According to a study completed by Canadian researcher Paul G. Taylor and published in a recent issue of *American Journal of Diseases of Children,* the way you dress may play a part in how your patients' parents rate your skills.

According to the study, parents were twice as likely to attribute competence to physicians in formal dress than to those in operating room scrubs — and confidence dipped even lower if the physician happened to be wearing traditional intern's garb. However, it made no difference to the parents whether the doctor was wearing a skirt or pants. In matters of competence, it seems, gender is not an issue.

Inherited alzheimer's?

The theory that Alzheimer's is an inherited disease received yet another boost from researcher Richard A. Mohs of New York's Mount Sinai School of Medicine. Mohs found data which suggest the existence and operation of a relatively common, dominant autosomal gene for Alzheimer's — a gene which is often delayed until late old age.

Mohs' findings, published in a recent issue of *Archives of General Psychiatry,* prompted him to note that "first-degree relatives of Alzheimer's disease patients show nearly a 50% cumulative incidence of probable Alzheimer's by age 86" — a figure which is four times the risk for a control group.

Although Mohs is quick to point out that the data is not conclusive, the evidence continues to mount . . .

Hypertension control

Some patients with moderately high blood pressure may be able to forego medication by losing weight and reducing alcohol and salt intake, according to a Northwestern University Medical School study reported in the *Journal of the American Medical Association.*

These findings were based on a four-year study of 189 hypertensive patients, including: group 1, who discontinued drug therapy and reduced weight and salt and alcohol intake; group 2, who discontinued drug therapy with no nutritional program; and group 3, who continued drug therapy with no nutritional program.

"Study findings demonstrated that nutritional therapy may substitute for drugs in a sizeable proportion of hypertensives or, if drugs are still needed, can lessen some unwanted biochemical effects of drug treatment," the researchers suggested.

Not surprisingly, those with the mildest forms of hypertension and those who are not overweight are the most likely to be able to control their blood pressure by diet alone, the researchers added.

MRI preferred screening

Magnetic Resonance Imaging (MRI) should be the preferred screening technique for children with suspected spinal cord problems, according to a University of Iowa study in the *Archives of Neurology.*

The study found MRI the preferable screening technique because it can be done on an outpatient basis and avoids potential radiation and other risk associated with standard diagnostic tools.

Stress and heart disease

A recent study in the *Journal of the American Medical Association* suggests there's a link between psychological stress and sudden cardiac death.

In a University of California-Irvine Medical Center study of 80 patients with life-threatening ventricular tachyarrythmias, researchers reported that while six patients had no underlying structural heart disease, five of them has experienced "marked psychological stress."

"This may be particularly important in individuals without detectable heart disease," the researchers suggest.



Warning required for sulfite-containing prescription drugs

A warning about possible allergic-type reactions, including anaphlyaxis, will be required in the physician package insert for prescription drugs to which sulfites have been added to the final dosage form, reports a recent issue of the FDA Drug Bulletin.

Sulfite-containing epinephrine for injection has an alternate warning statement. Epinephrine should still be used for treating serious allergic or other emergency situations, even for patients known to be sulfite-sensitive. The benefits of using epinephrine, even if containing a sulfite, for the treatment of these conditions outweigh possible disadvantages, it continues.

This amendment to the drug labeling regulations went into effect June 3, 1987. About 1,100 drugs, mostly intravenous solutions and injectables, contain sulfites added as preservatives.

Disease connection

An atypical virus may be the cause of both Alzheimer's disease (AD) and Down's syndrome (DS), according to a report in the *Journal of the American Medical Association.*

The report states that while AD may be solely a genetic disease, evidence suggests the environment and a specific causative agent may induce its development in some genetically susceptible individuals. Environmental factors may also influence nondisjunction — leading to the gene surplus that causes DS symptoms, the researchers point out.

OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

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Second Opinion . . . *continued*

We have nothing to apologize for, whether it be our medical services or our economic successes.

partly united are invincible. All that is needed is to wake this sleeping giant. We do have truth on our side and, at this time, still have an enormous amount of economic power. But as each day goes by, our strength is sapped. There can really be no further delay in action. The continued appeasement and acquiescence to the regulations and whims of those who are so ignorant that they know not their ignorance, will be the deathknell of our profession. History teaches us that any group of free men or any free nation, long before it loses its liberties, invites with open arms its enemies to its outer gates. They do this by intellectual weakness and by not fighting for the principles upon which their freedoms are founded. The only thing which allows evil to triumph is when good men do nothing.

Medicine requires complex but, above all, highly individualistic decisions. It is not conducive to assembly line, production-like manufacturing. It is not conducive to efficiency. Above all, it is not conducive to external regulations which impinge on the decisions made by the physician and patient. This truth alone is our greatest asset. When explained to the public, it is well-accepted. But our spokesmen and leaders have not done a good job of getting this across. They instead have accepted the methodologies of our enemies, thus legitimizing them. Our fight must be an ideological one, a philosophical one. It cannot be won with statistics.

I would like to propose to you the possibility of a change. I know that this organization has a long and proud tradition of service to the profession and community. But times have changed and we are now literally fighting for our professional integrity and lives. I ask you for your consideration as members of this organization that the direction of this academy be newly-pointed toward the problems which I have just discussed. Whether this organization becomes a political action committee or a forum for debate, I do feel that it is time for change. I feel it is a little bit absurd to be wasting our time with mundane issues when there are such grave threats to our profession. I propose this only to open debate. Where this might lead, I do not know, but the debate needs to begin.

We belong to the most noble profession in the world, bar none. We have nothing to apologize for, whether it be our medical services or our economic successes. Those amongst us who see our imperfections and wish to correct them by outside influences which restrict liberty succumb to the utopian fantasy which has destroyed so many countries and institutions. Because of the Constitution of which I have spoken and its guarantees of freedom of speech, freedom of the press, and freedom of assembly, anything can still be done in this country. And if not by us, then by whom? If not now, then when? We must begin to fight back or face the evil consequences of inaction. **OSMA**

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of OHIO Medicine *or the Ohio State Medical Association.*

OHIO MEDI-SCENE

Women physicians take the lead . . . mild symptoms characterize circulatory disease . . . transfer type tattoos . . . the lung health study . . . OSMA science award winners . . .

Women physicians take the lead

They've come a long way . . . three women physicians from Ohio have recently emerged in the upper hierarchy of organized medicine: Claire V. Wolfe, MD, a Columbus physiatrist, as president of the Academy of Medicine of Columbus and Franklin County; Wilma F. Bergfeld, MD, a Cleveland dermatologist, as president of the Academy of Medicine Cleveland; and Ellen J. Buerk, MD, an Oxford pediatrician, who is rounding up a year as Butler County Medical Society president.

Considering that these "key spots" have traditionally been occupied by physicians of the other gender, these accomplishments are no small feats. But as increasing numbers of women filter into the medical profession, they will naturally begin to assume roles in the upper ranks, both Drs. Buerk and Wolfe agree. And, before long, novelty titles such as *first woman physician president* will become passé.

Women now comprise approximately 13% of the physician population, but recent statistics, which include women medical students and resident physicians, project the total will climb close to 30% in the future. With a potential of 30% of the physician population, women physicians "need to have a say in what's happening, and about how things are being done and run," says Dr. Wolfe.

And Dr. Wolfe is optimistic about the future of women in organized medicine. Offering words of encouragement, she says, "I haven't encountered any prejudice along the way because I'm a woman."

Already, signs are evident that a trend toward greater involvement by women physicians is underway, she continues. In 1972, Dr. Wolfe says she counted just eight women delegates/alternate delegates to the AMA House of Delegates Meeting. By 1986, she tallied about 40, and this year she says there will probably be even more.

Which all leads to a very important point: "We need members," she emphasizes. "We need women members. We have to figure out some way to attract them, so we try to bombard them every way we can — at the local, state and national level."

That's why Dr. Wolfe supported Resolution 25-87, which called for the implementation of a statewide Women in Medicine Committee and encouraged local women physician programs. At the 1987 OSMA House of Delegates



Claire V. Wolfe, MD



Ellen J. Buerk, MD

OHIO MEDI-SCENE

Women physicians take the lead . . . *continued*

Meeting, however, the resolution came up against a wall of resistance and collapsed.

Most of the physicians who discussed the resolution on the House floor — the majority of whom were women — maintained that the resolution was discriminatory because it segregated women physicians. As one physician stated, "The OSMA should spend money and direct efforts on important issues which affect all physicians."

Dr. Wolfe concurs that "women physicians don't want to be singled out," but she supported the resolution because she saw it essentially as a *membership mechanism.* "The purpose of the special committee is primarily to make an additional vehicle of membership available," she says.

Unfortunately, her position as vote teller at the House of Delegates prevented her from approaching an open microphone to voice her support for the resolution, she says, but she adds that she has hopes the resolution will resurface in the future.

"My gender has never made any difference in anything I've ever done . . ."

Classmates during their medical residency stints at the Ohio State University College of Medicine, Drs. Buerk and Wolfe share similar views about breaking into "untraditional roles."

As Dr. Buerk points out, "My gender has never made any difference in anything I've ever done. In my experience, people view you for your abilities, not for your sex."

But unlike her colleague, Dr. Buerk opposes the Women in Medicine resolution, which she, like others, views as discriminatory. She favors, instead, the slight reduction in fees for two-physician families to enhance membership, although she adds that Butler County as a whole did not favor the two-physician reduction.

Dr. Buerk says that sometimes women physicians do not get involved in organized medicine because of family responsibilities or other interests. "Everybody has different interests. Some physicians may not be interested in being leaders," she adds.

According to Dr. Wolfe, the proposed Women in Medicine committee would be similar to the Women in Medicine Project established by the AMA in 1984 (see related sidebar). The AMA project, Dr. Wolfe points out, is not intended as a separate section, but as an impetus to increase membership and involvement of women physicians.

"We want these committees to first and foremost attract membership and, then, perhaps, to address some issues particular to women themselves. But first we need to get women interested and let them know what organized medicine can do for them."

That's why one of Dr. Wolfe's primary goals as president of the Columbus Academy of Medicine is to concentrate on making the society more attractive to the membership and to attract new members. To this end, she's got a few ideas up her sleeve — one of which is to visit hospital staff meetings to try to garner support by explaining why medical societies are important to join.

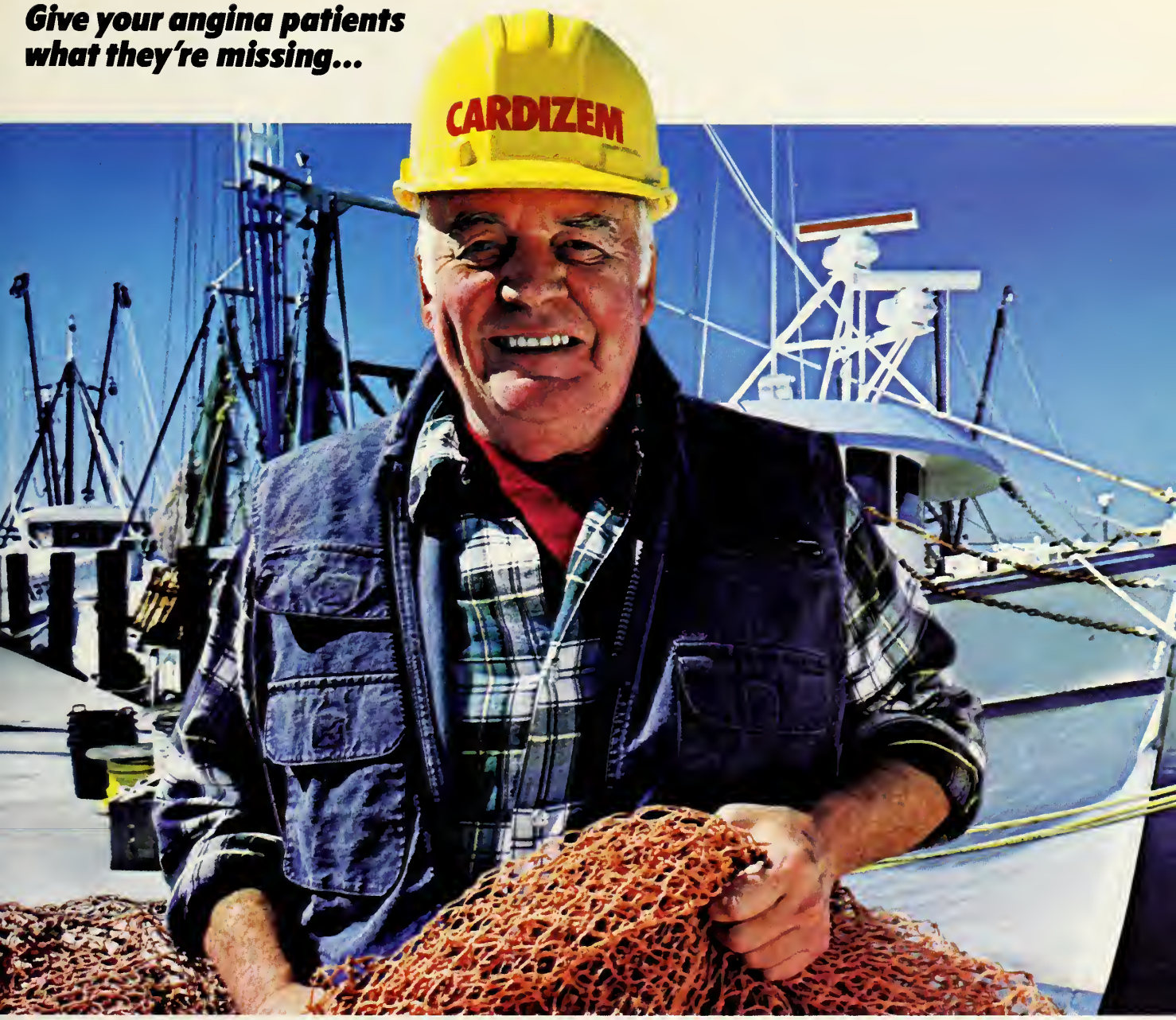
Another facet of her membership campaign is geared toward improving communications, in order "to keep the society more tuned in and informed about the issues which affect them," she explains. This goal will include stimulating more positive press, with a greater emphasis on boosting public relations and visibility.

Dr. Buerk's year as Butler County president, which is drawing to a close, has been busy as she has combined roles as society president; chairman of the Pulmonary Standards Committee for Crippled Children for the State of Ohio; and executive committee member of the Ohio Academy of Pediatrics with her duties as teacher and pediatric practitioner.

"You do have to juggle your life sometimes," she admits, although she says the past year has been "lots of fun." The society devoted efforts to a variety of projects, including highway improvement, child abuse and the passage of malpractice tort reform, she adds.

And Dr. Wolfe, who is just beginning her year as society president, says she is looking forward to it, although she admits

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   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration at doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase*
Dermatologic	*Petechiae, pruritus, photosensitivity, urticaria*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 7/86*

See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnston DL, Lesaway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease. When to use which. Mod Med 1982;50(Sept):94-116.*

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there are many challenges ahead. One of these challenges, she explains, is the fragmentation of today's physicians — who are often so divided by hospitals, group practices, medical and specialty societies that they have lost a feeling of unity, especially in larger counties.

"Physicians used to faithfully join their societies, but that sense of belonging is disappearing." Thus, part of Dr. Wolfe's challenge will be to try to revive that unifying spirit.

As Dr. Buerk concludes, "In the future, physicians should work together for political concerns which affect us all and which should be addressed and changed as necessary." — *Deborah Athy*

The AMA's "Women in Medicine" Project

Unfortunately, women are still not as actively involved in organized medicine as men, says a report recently issued by the American Medical Association. According to the AMA, only 28% of active women physicians are members compared to 45% of male physicians, though this figure does represent an increase over previous years.

The AMA established the Women in Medicine Project in 1984 to promote women's involvement in organized medicine activities. The project coordinates AMA initiatives addressing women physicians and medical students, including membership development, leadership training and joint activities with special sections of the AMA. It also serves as a resource and clearinghouse for information on women in medicine.

The project is guided by a seven-member physician and medical student advisory panel. They are working to ensure that women physicians and medical students are "fully mainstreamed" into organized medicine. — *Karen S. Edwards*

Mild symptoms, dangerous consequences often characterize circulatory diseases

The symptoms of circulatory diseases can be mild, deceptive and varied, speakers at a recent symposium on Vascular Disease told more than 300 family practitioners from throughout central Ohio.

Further, these symptoms may warn of diseases capable of killing, disabling, or crippling the patient in short order.

"Any organ or extremity can react with pain or malfunction if deprived of bloodflow," said Thomas Hartranft, MD, director of the day-long symposium held at Mount Carmel Health in Columbus.

"The symptoms may well be simply local pain or numbness — something that could originate in the organ itself, in stress, in a simple injury — but if the cause is circulatory disease, tissue in the area may start to die fairly quickly," he said.

The symposium featured discussions of the full range of common diseases and disorders of major arteries and veins.



OHIO MEDI-SCENE

Mild symptoms characterize circulatory disease . . .

continued

Attendees were told if you even suspect circulatory causes, check them out — fast. "Waiting can be fatal when you're dealing with circulatory disorders," Hartranft advises.

As an example, Larry Hollier, MD, head of the Section of Vascular Surgery at the Mayo Clinic, cites the symptoms announcing mesenteric ischemia: abdominal pain, mild tenderness, hemoconcentration, peritoneal signs and sometimes pain after eating. Such symptoms are so frequently seen in general practice that physicians may not notice anything in the history to indicate serious or immediate danger.

However, Hollier continues, waiting seriously narrows the physician's treatment options.

If the disease is detected early enough, the arteries supplying the intestine can be revascularized to restore circulation and retain tissue viability, he says.

"Waiting can be fatal when you're dealing with circulatory disorders."

Other symposium speakers gave similar warnings about circulatory diseases affecting vessels supplying such key areas as the brain, the spinal cord, the kidneys and the heart.

Ischemia of brain secondary to carotid artery lesions may be announced by such symptoms as weakness, numbness, paralysis on one side of the face and monocolor blindness. Angiography is the best tool for detecting actual lesions in the artery. The only treatment is surgery to restore bloodflow in the artery. E. William Blaisdell, MD, chairman of the Department of Surgery at the University of California at Davis, told the symposium that surgery is generally indicated if the patient has a bilateral obstruction, or 70% unilaterally.

Ischemia or aneurysm of the thoracic aorta is often heralded only by pain that radiates from the back, according to Hollier. Untreated, the patient will almost certainly die. Yet treatment always involves a serious risk of paraplegia.

Aneurysm of the abdominal aorta may produce no symptoms at all before it ruptures, according to Robert Navarre, MD, clinical professor of surgery at the Medical College of Ohio at Toledo. Patients with large aneurysms may show mild bloating or even a noticeable, pulsating mass in the abdomen. Large aneurysms should be treated through surgical replacement of the swollen section of the artery, Navarre said, to avoid the risk that the aneurysm will rupture and cause serious internal damage or even death.

Peripheral Venous Disease is a less critical circulatory disorder, characterized by swelling, distention and puffiness, according to John Cranley, MD, director of the Vascular Laboratory at Good Samaritan Hospital in Cincinnati. But peripheral venous disorders can be particularly insidious if untreated. Treatment is always elevation and wearing elastic stockings that reduce swelling and assist the return of blood to the heart. "Any venous lesion will heal if it can be elevated above the heart," Cranley added.

While arterial diseases are often difficult to diagnose, the treatment is generally easy to choose — restoring circulation by opening the vessel. One new technique that holds promise of restoring bloodflow with less trauma to the patient is laser angioplasty, soon to be available for patients at Mount Carmel through the new Advanced Treatment and Bionics Institute.

Mount Carmel will be one of only a few facilities in the nation conducting clinical trials in laser angioplasty, and offering another FDA-approved laser angioplasty technology to the public. — *Jody Gossage,* Mount Carmel Health, Columbus

Nicotine gum

Nicotine gum, when used in conjunction with a physician's advice and counseling, is a cost-effective therapy for smokers, says a study in the *Journal of the American Medical Association.*

The cost-effectiveness, which was expressed in cost per year of life saved among patients offered a prescription, was based on the physician's time to prescribe the gum and the patients' cost of purchasing it.

Beware of transfer-type tattoos

It looks simple and harmless enough.

You choose a design from the sheet of tattoos in your hand, cut it out, lay it on your arm (or wherever you would like the design to appear), moisten it with a cloth or sponge and presto — you have an instant tattoo that is "permanent" until your next bath.

Transfer tattoos have always been popular among the young set — but diabolical minds are now using transfer tattoos as a new means of exposing unsuspecting children to the hallucinogenic drug LSD (street name, "acid").

According to San Diego Police authorities, small sheets of white paper with blue stars, about the size of pencil erasers, are readily available to children. Each star has "LSD" printed on it and each can be easily removed from the paper and placed in the mouth. Yet, since absorption can also occur through the skin, handling and touching the tattoo can be equally dangerous.

In addition, some LSD has been placed on brightly-colored, postage stamp sized tabs which have been decorated with pictures of Superman, Mickey Mouse and other Disney characters. These tabs come in red cardboard boxes, are wrapped in foil and usually sealed in a clear lock-type bag.

Authorities fear that young children could come across these products, and with the current popularity of stickers, be innocently attracted to them. They also fear that older children "wanting some fun" may offer a free tattoo to a younger child. In either case, the tattoo is likely to prove fatal.

Children in the southwest portion of the state have already been exposed to the tattoos, so they are no longer a "California phenomenon." Be alert — and beware!



The lung health study

What's done can't be undone — or can it?

That's the question a group of researchers at Case Western Reserve University are attempting to answer — whether it's possible to alter or slow the progression of lung damage in smokers who kick the habit.

Funded by a grant from the National Heart, Lung and Blood Institute, the Lung Health Study has established nine study sites in the U.S., including John Hopkins Hospital in Boston; The Mayo Clinic in Rochester; Henry Ford Hospital in Detroit; and the University of California in Los Angeles.

Each site will conduct clinically controlled studies of about 600 smokers — 6,000 altogether — to assess the benefits of early smoking intervention for chronic obstructive pulmonary disease (COPD), of which cigarette smoking is a contributory factor. COPD, which includes emphysema and chronic obstructive bronchitis, is reported to be the fifth leading cause of death in the U.S.

Murray Altose, MD, principal investigator of AIRWAYS, the Ohio-based study, and chief of pulmonary services at Cleveland Metropolitan General Hospital, says the outcome of the study is significant, because of the increased magnitude of COPD mortality and the impact these illnesses have on health care costs.

AIRWAYS officially got off the ground in October 1986 and, to date, has enrolled about 100 participants. Dr. Altose says the study will continue accepting volunteers until 1988 or until 600 participants have been enrolled.

The researchers are looking for test subjects who are cigarette smokers between the ages of 35 and 59 and who show a mild abnormality in lung functioning, but who are otherwise in good health.

Participants will be divided into three groups: Group 1 will undergo annual lung functioning screenings; Groups 2 and 3, in addition to the annual screenings, will take part in

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The lung health study . . . *continued*

intensive, state-of-the-art smoking cessation programs replete with nicotine gum and relaxation techniques.

In addition, Group 2 will be given a placebo inhaler, and Group 3 will be given an anticholinergic drug, ipratroprium bromide (tradename Atrovent®), which was FDA-approved in April. Atrovent®, a long-standing bronchodilator, "serves to relax the bronchial tubes and minimizes the reactivity of the bronchial smooth muscle," Dr. Altose says. Administration of both the drug and placebo will be done in a double-blind manner, he adds.

An important question which will be addressed during the five-year study is: "Does early intervention via a program of smoking cessation and physician-prescribed bronchodilator medication slow the rate of decline of lung function among cigarette smokers who are at high risk for developing COPD?"

While it is still too early to answer this question, "other studies suggest that smoking interventions are apt to produce a beneficial effect on the lungs," Dr. Altose points out. If so, this type of program — instituted nationwide — could have a major effect on reducing COPD mortality.

The study is not designed to provide medical care for the participants, Dr. Altose emphasizes. If individuals are found to have serious lung injuries, they will be referred to their personal physicians. In addition, the results of the testing will be shared with personal physicians with the permission of the participants.

Interested individuals are encouraged to call for a free lung functioning screening at (216) 459-LUNG. As an AIRWAYS brochure points out: "Call today. You might even breathe a little easier." — *Deborah Athy*

Art and Culture Committee Exhibit

The Art and Culture committee of the Ohio State Medical Association will present a poster exhibit during the Clinical and Scientific meeting to be held in Columbus in September.

The series of four prints were first published in 1587 under a title of "The Medical Profession." They were engraved by Henrik Gotzius at Haarlem in the Netherlands. This progression of engraved scenes traces the reactions relating to the patient's image of the Doctor at various stages of the relationship. During the care, the Doctor is depicted as a deity. After the crisis, he is demoted to an angel; later he is a mere man; and finally, when submitting the bill, he becomes a devil. Exactly four hundred years later, is it different? The exhibit was initiated and developed by Ralph Fried, MD, Cleveland. — *Harry H. Fox, MD, chairman, OSMA Art and Culture Committee*

"Growth factors from osseous tissue" takes OSMA's top science award

Christine S. Brown, an 11th grade student from Benjamin Logan High School, Zanesfield, was named by OSMA's 12-physician judging team as winner of the association's top award during the 39th Annual State Science Day on May 2 at Ohio Wesleyan University, Delaware.

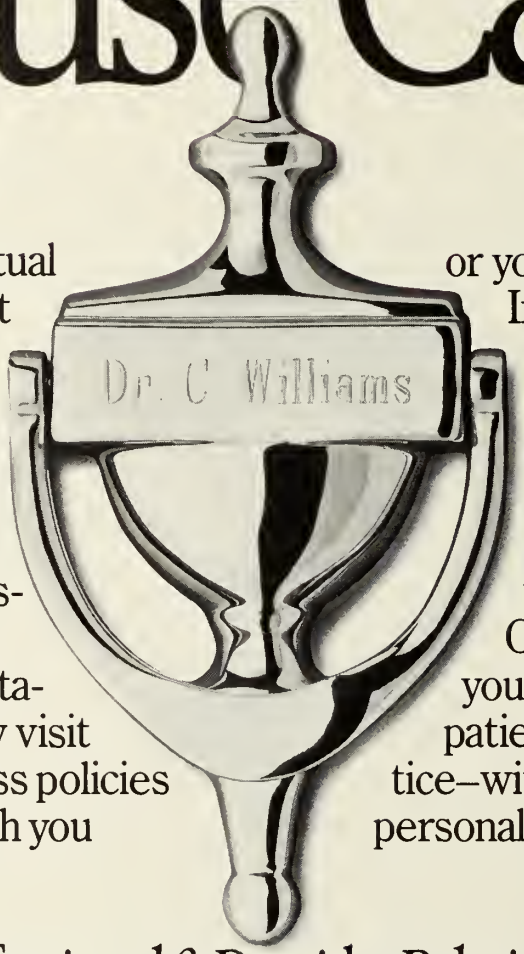
Brown's exhibit was entitled "The Extraction of Growth Factors from Osseous Tissue." Evan W. Dixon, MD, Bellefontaine, president of the Logan County Medical Society, presented a plaque and a $100 U.S. Savings Bond to Brown during a Benjamin Logan High School awards assembly.

Five grade level winners also received special plaques from OSMA.

This marked the sixth consecutive year that OSMA has sponsored State Science Day awards. The event is under direction of the Ohio Junior Academy of Science, a branch of the Ohio Academy of Science.

D. James Hickson, MD, Mt. Gilead, is chairman of the OSMA judging team. Vice chairman is Melanie S. Kennedy, MD, Columbus.

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OHIO STATE MEDICAL ASSOCIATION

Clinical Update
and Exposition

September 18, 19 & 20, 1987

Hyatt Regency Columbus
at Ohio Center

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UPDATE

The Programs . . .

Editor's Note: *The following is a partial listing of programs which were available at press time.*

ADVANCED TRAUMA LIFE SUPPORT COURSE

Date: September 18 & 19

Sponsored by: Grant Medical Center, Columbus, Ohio Committee on Trauma, American College of Surgeons. In conjunction with: Ohio State Medical Association Clinical Update.

Course Description . . .

The patterns of care and outcome of victims suffering severe trauma are greatly influenced by the judgments exercised by the physician on initial contact with the patient. The primary response to patients with major trauma is of critical importance and is facilitated by a well-organized plan to assess life-threatening injuries and institute appropriate stabilization and therapy in order to make possible definitive therapy at the appropriate time.

Primary assessment is often futile if measures are not immediately initiated to prevent further deterioration of the clinical status of the trauma patient. The responsibility for appropriate care of critically injured patients rests with the emergency department physician. Appropriate care can only be accomplished after initial assessment and lifesaving priorities are established.

The Advanced Trauma Life Support (ATLS) Courses are designed with these factors in mind. The courses combine didactic lectures and practical stations, which allow the participant time to perfect his/her skills in the initial assessment, and stabilization phases of trauma patients. The instructor course offers didactic and practical teaching sessions to provide an opportunity for the participant to practice skills in teaching as well.

The ATLS Courses have been specifically designed for the primary care physician, emergency department physician and surgeon.

Course Objectives

Upon completion of the ATLS course, the participant will be able to:

I. Demonstrate concepts and principles of patient assessment
II. Establish management priorities in a trauma situation
III. Initiate primary and secondary management necessary, within the first hour of emergency care, for acute life-threatening emergencies
IV. Demonstrate the skills necessary in initial management of trauma victims
- •Initial assessment of victims with multiple injuries
- •Application of anti-shock garment
- •Initiation of intravenous therapy with CVP and shock management
- •Adult/infant intubation and nasotracheal intubation
- •Radiographic identification of C-Spine injuries
- •Cricothyroidotomy
- •Pleural decompression and chest tube insertion
- •Pericardiocentesis
- •Peritoneal lavage
- •Venous cutdown
- •Extremity and spinal immobilization
- •Head trauma management with application of cervical traction tongs

Provider Course Schedule

DAY 1

7:30 am-5 pm

Lectures:

Course overview & introduction to ATLS
Initial Assessment
Upper Airway Management
Shock
Thoracic Trauma
Abdominal Trauma

Practical:

Radiographic identification of C-Spine injuries
Upper Airway Management
Anti-shock garment application
IV/Shock Therapy

Surgical Skills Practicum

Cricothyroidotomy
Peritoneal Lavage
Pericardiocentesis
Chest decompression/tube insertion
Venous cutdown

DAY 2
8 am-5 pm
Lectures:
Head Trauma
Neck/Spinal Trauma
Extremity Trauma
Burns
Pediatric Trauma/Trauma in Pregnancy
Stabilization and Transport
Practical:
Mr. HURT
Extremity Immobilization
Spinal Immobilization
Initial Assessment — Practice/Test
Triage Scenario Booklet
Written Test

Credits

As organizations accredited for continuing medical education, the American College of Surgeons and the American College of Emergency Physicians designate the Provider course as meeting the criteria for 16 Category I hours.

General Information

This program is sponsored by Grant Medical Center at Baldwin Tower, 300 East Town Street, Columbus. For more information on this or other ATLS courses, contact:
Marlene Hanson, registrar, (614) 461-3019

or

Jan Price, RN, CCRN, trauma nurse coordinator, Grant Medical Center, 111 South Grant Avenue, Columbus, Ohio 43215 — (614) 461-3232.

Registration Information

Registration fee for the Provider Course is $300. ENROLLMENT FOR EACH COURSE IS LIMITED TO A TOTAL OF 32 PHYSICIAN PARTICIPANTS. Registration fees include all course materials, lunch, and refreshments.

Courses fill rapidly, so early registration is encouraged. Registration fees must be received at least three weeks before the scheduled course in order that participants may receive their manuals in sufficient time to prepare for taking the ATLS course

Cancellation Policy

Registration cancellations postmarked two weeks before the scheduled course will be assessed a $50 processing fee which will be deducted from the refund. No refunds will be offered after that time

ATLS REGISTRATION FORM

Registration limited to 32 participants; please enroll early.
Registration Fees: Provider Course $300.00
Make checks payable to **Grant Medical Center** and return with this form to:

Jan Price, RN, CCRN
LifeFlight/Trauma Services
Grant Medical Center
111 South Grant Avenue
Columbus, Ohio 43215

Name _____

Address _____

City, State, Zip _____ SS No.:_____

Telephone (Office): _____ (Home) _____

Area of Practice: ER_____ Family Prac._____ Other (specify): _____

Hospital(s) Affiliation _____

ALTERNATIVE DELIVERY AND FINANCING SYSTEMS: YOUR OPTIONS AND HOW TO EVALUATE THEM

Date: **Saturday, September 19**
Time: **8:30 am-noon and 1:30 pm-5 pm**

Presented by: AMA Practice Management Department: This AMA Practice Management workshop explains the components and functions of HMOs, PPOs, and other health care delivery systems.

Designed to help physicians make informed decisions about their participation in these systems, this intensive, one-day course demonstrates the applicability and viability of various systems to each physician's specific practice situation. By attending, physicians will explore their current business goals and consider objectives for reaching them: hear suggestions on practicing high-quality, cost-effective medicine; learn from experiences of others' participation in the systems; and get hands-on practice in evaluating contracts. Case studies take participants step-by-step through decision making processes.

A detailed workbook that contains course materials, an outline of market research resources, a list of sources for additional information and assistance, and a bibliography of related books and articles on alternative delivery systems will be included.

APPLICATIONS OF SPECIALIZED MODERN DIAGNOSTIC IMAGING

IN CLINICAL MEDICINE

Date: **Saturday, September 19**
Time: **1:30 pm-3 pm**

Presented by: Ohio State Radiological Society: This course is to illustrate for physicians of various specialties the diagnostic usefulness of computed tomography, duplex Doppler ultrasound, and magnetic resonance imaging in three stated areas of clinical concern. The course is directed to internists, surgeons, radiologists, neurologists, family physicians, emergency physicians, neurosurgeons, vascular surgeons and orthopedists.

Course Director: Alan E. Oestreich, MD, Division of Roentgenology, Children's Hospital, Cincinnati

Presiding: Judy L. Greene, MD, staff radiologist, Kettering Medical Center

Speakers:

CT Evaluation of the Traumatized Abdomen: Charles F. Mueller, MD, FACR, professor of radiology, Ohio State University

Duplex Doppler Ultrasound Imaging in Extracranial Carotid Disease: Judy L. Greene, MD

The Use of Magnetic Resonance (MR) in the Evaluation of the Lumbar Spine: Ronald J. Lorig, MD, staff radiologist, Cleveland Clinic Foundation

CONSERVATIVE MANAGEMENT OF BREAST CANCER

Date: **Sunday, September 20**
Time: **8:30 am-noon**
Course Objectives:

1. Describe the surgical technique of lumpectomy and axillary node dissection
2. Describe radiation techniques in breast conservation
3. Review results of clinical trials in breast conservation
4. Review of surgical techniques for non-invasive breast cancer

Target Audience: Family Practice Physicians, General Practitioners, Surgeons, Internists, Radiation Therapists, Medical Oncologists

Course Director: Donna Stahl, MD, associate professor of surgery, University of Cincinnati Medical Center

Presiding: John W. Vester, MD, chairman, OSMA Committee on Education, University of Cincinnati Office of Continuing Education

Speakers:

Conservative Surgical Approach for Invasive Breast Cancers: Donna Stahl, MD

Radiation Treatment in Breast Conservation: Bernard Aron, MD, professor and director, Division of Radiation Oncology, University of Cincinnati Medical Center

Update of Clinical Trials in Breast Conservation: Martin Popp, MD, associate professor of surgery, University of Cincinnati Medical Center

The Surgical Approaches in Non-Invasive Breast Cancer: Intraductal and In Situ lobular: John P. Minton, MD, professor of surgery, Ohio State University Hospitals

DEPRESSION IN THE PRIMARY CARE PATIENT: INCREASING DIAGNOSIS AND IMPROVING TREATMENT OF A GROWING PROBLEM

Date: **Saturday, September 19**
Time: **8:30 am-noon**

Presented by: The Ohio Psychiatric Association

Course objectives: 1) To assist physicians in diagnosing covert depression. 2) To enhance the physician's ability to assess suicidal risk. 3) To help enhance the physician's ability to use anti-depression medications. This course is for primary care physicians.

Course Director: Daniel A. Deutschman, MD

Presiding: Jerome A. Logan, MD, president, OPA

Speaker:

Dr. Daniel A. Deutschman, Cleveland

EFFECTIVE USE OF PHYSICIAN ASSISTANTS

New federal reimbursement policies, can they affect your practice?

Date: **Friday, September 18**
Time: **1:30 pm-3 pm, and 3:30 pm-5 pm**

Presented by: The Ohio Association of Physician Assistants: The objectives of this course are to offer ideas on how to maintain control of your practice and expand your practice base through the use of the Physician Assistant, and to become familiar with the new federal regulations allowing for the practice to be reimbursed for PA services.

This course is targeted to all physicians whose practices have been affected by the dynamic changes taking place in the health care system.

Course Director: Samuel K. Roth, PA-C, legislative chairman, Ohio Association of Physician Assistants

Presiding: Gregg Grooms, PA-C, president, Ohio Association of Physician Assistants

Speakers:

Samuel K. Roth, PA-C, Ohio Association of Physician Assistants

F. Lynn May, executive vice-president, American Academy of Physician Assistants

Gregory Grooms, president,

Ohio Association of Physician Assistants

GERIATRICS I — Interdisciplinary Approach: Diagnosis and Treatment of Behavioral Problems of the Elderly

Date: **Friday, September 18**
Time: **1:30 pm-1:45 pm**
Introduction: Donald J. Vincent, MD
1:45 pm-2:15 pm
Depression: Philip Hinkle, MD
2:15 pm-2:45 pm
Psychological Testing and its Significance in Dementia: David Tennenbaum, PhD
2:45 pm-3 pm
Day Care Center: Patricia Botic, RN, MSN
3 pm-3:15 pm
Break
3:15 pm-4 pm
Medical Assessment and Treatment of Dementia: James Kvale, MD
4 pm-4:45 pm
Case Presentation: Gerontology Evaluation Team
4:45 pm-5 pm
Discussion — Question and Answer Period

GERIATRICS II — Overdose in the Elderly: An Interdisciplinary Concern

Date: **Saturday, September 19**
Time: **1:30 pm-5 pm**
Presented by: Ohio State Medical Association/Ohio Nurses Association/Ohio Osteopathic Association
Course director: Carol A. Jenkins, associate executive director, Ohio Nurses Association
Speakers:
Overview of the Problem: Claire V. Wolfe, MD, chairman, OSMA Nurse Liaison Committee
Geraldine Price, RN, MS, chief, Bureau of Support Services, Ohio Department of Health and Member, OSMA-ONA-OOA Liaison Committee
Objectives:
Identify the problem of overdose in the elderly from the nurse/physician perspective
Special Concerns of the Pharmacist: Phyllis K. Wilson, RPh, clinical consultant pharmacist and president, Nursing Center Services, Inc. (NCS)
Objectives:
1. Participants will gain an increased understanding of polypharmacy; improper dosing; lack of compliance; adverse effects; and OTC use
2. Participants will receive an update of the pharmacology of drugs in the elderly

Problems in the Nursing Home Setting: Overlap to Overdose: Debbie A. Freece, RN, M, geriatric nursing consultant, Columbus
Objectives:
1. Describe drug misuse in LTC facilities
2. List strategies to prevent drug misuse in LTC facilities

Problems in Home Health Care: Marlene Hollstein, RN, BSN, staff nurse, 60plus program, Visiting Nurse Service of Toledo District Nurses Association
Objectives:
1. Describe drug misuse in home health care facilities
2. List strategies to prevent drug overdose in home health care facilities

GERIATRIC III

Date: **Sunday, September 20**
Time: **8:30 am-noon**
Presented by: The Ohio Nurses Association
Course Director: Carol A. Jenkins, associate executive director, Ohio Nurses Association
Presiding: Carol A. Jenkins
Speakers:
Alzheimer's: Wandering Behavior: Ann McCracken, RN, PhD
At the conclusion of this session participants will:
1. Be able to state two theories related to wandering behavior in Alzheimer's Disease
2. Be able to instruct families in four interventions to use in responding to wandering behavior

Pet Therapy for Older Adults: Evelyn Bohlinger, RN, MSN
Objectives:
1. Explore biopsychosocial benefits of pets related to the well-being of older adults
2. Identify a variety of pet-facilitated interventions designed to enhance the well-being of older adults
3. Recognize potential risk factors related to pet-people interactions
4. Discuss existing research data related to the use of pet-facilitated interventions with older adults

Urinary Incontinence of the Elderly: Ella Kick, RN, DNSc
Objectives:
1. Relate the prevalence of urinary incontinence among the elderly
2. Interpret the psychosocial aspects of urinary incontinence
3. Explore environmental causes of urinary incontinence
4. Describe one non-medical method for treating chronic urinary incontinence
5. Value nurse/physician collaboration in the treatment of urinary incontinence

Mental Health and the Older Adult: Eldonna Shields-Kyle, RN, MS
Objectives:
1. Describe demographics of mental health needs of older adults
2. Identify factors that predispose

the older adult to mental health problems
3. Discuss common mental health problems in older adults
4. Discuss the depressive side effects of medications commonly used with older adults

MANAGEMENT OF CHRONIC NECK AND LOW BACK PROBLEMS

Date: **Saturday, September 19**
Time: **8:30 am-noon**

Presented by: Ohio Society of Physical Medicine and Rehabilitation

Course Director: George W. Waylonis, MD, director of physical medicine, Riverside Methodist Hospital

Presiding: Dr. Waylonis

Speakers:

Diagnosis and Management of the Cervical Syndrome: George W. Waylonis, MD

The Diagnosis and Management of the Acute and Low Back and Chronic Low Back Syndrome: Myron J. LeBan, MD, director of physical medicine, William Beaumont Hospital, Royal Oak, Michigan

Panel Discussion: "Management of the Refractory Neck and Back Patient: Discussants: Drs. LeBan, Waylonis and Patricia A. Wongsam, MD

NEW CONCEPTS IN PLASTIC SURGERY

Date: **Saturday, September 19**
Time: **8:30 am-noon**

Presented by: OSMA Section on Plastic Surgery

Course Director: James Apesos, MD, chairman, Department of Plastic Surgery, Kettering Medical Center/Wright State University

Presiding: Dr. Apesos

Speakers:

Suction Lipectomy Techniques: Ravi Devara, MD

Secondary Reconstruction Following Moh's Chemosurgery: Gloria Thomas, MD

Flap Reconstruction Following Sternal Dehiscence: Sherif Khattab, MD

Infant Craniofacial Surgery: Alan R. Shons, MD, PhD

Recent Advances in Microsurgery: Brian Windle, MD

The Effects of External Electricity on Wound Healing: Allan Perry, MD

Fingertip Reconstruction: Dr. James Apesos

Aesthetic and Reconstructive Surgery of the Breast and Abdomen: Dr. Brian Windle

THE PHARMACO-THERAPEUTIC APPROACH TO ASTHMA AND ALLERGY

Date: **Sunday, September 20**
Time: **8:30 am-10 am**

Presented by: Ohio Society of Allergy and Immunology

Learner Objectives:

Broad review of mediators involved in Asthma/Allergy and Pharmaco-Therapeutic interventions

Target Audience: Pediatricians, Internists, Family Practitioners

Course Director: Joseph D. Bullock, MD, Columbus, president, Ohio Society of Allergy and Immunology

Presiding: Dr. Bullock

Speaker:

James P. Kemp, MD, San Diego, California

PIGMENTED LESION OF SKIN: DIFFERENTIAL, PATHOLOGICAL AND LEGAL CONSIDERATIONS

Date: **Saturday, September 19**
Time: **10:30 am-noon and 1:30 pm-3 pm**

Learner Objectives:

The conferees will be able to employ proper judgment in deciding which pigmented skin lesions to biopsy, and employ proper technique.

The conferees will be able to state the significance, in terms of patient management, of the dysplastic nevus syndrome.

The conferees will be able to state the legal consequences as regards diagnosis and management of pigmented skin lesions.

Target Audience: Physicians/Pathologists/Dermatologists

Course Director: John C. Neff, MD, Columbus, program director, Ohio Society of Pathologists

Presiding: Dr. Neff

Speakers:

Patrick J. Sheehan, JD, staff judge advocate, Office of the Surgeon General, Department of the Navy

Arthur E. Pellegrini, MD, assistant professor, Pathology/Dermatopathology, Ohio State University

PLENARY SESSION ON AIDS

Date: **Friday, September 18**
Time: **8:30 am-noon**

Learner Objectives:

1. To understand the clinical manifestations of HIV (Human Immunodeficiency Virus) infection
2. To be aware of the latest developments regarding AIDS
3. To understand the epidemiology and transmission of HIV
4. To understand how to develop AIDS educational programs in the office setting
5. To understand the appropriate use of the HIV antibody test

Target Audience: private

practitioner working in an office setting

Course Director: Thomas Halpin, MD

Presiding: Albert N. May, MD

Speakers:

Michael Lane, MD, director, Center for Preventive Medicine, Centers for Disease Control, Atlanta, Ga.

Leonard Calabrese, DO, head, Section of Clinical Immunology, Cleveland Clinic Foundation

Michael Lederman, MD, assistant professor of medicine, Case Western Reserve University, Department of Medicine, Cleveland

Thomas J. Halpin, MD, chief, Bureau of Preventive Medicine, Ohio Department of Health, Columbus

Albert N. May, MD, clinical associate professor of pediatrics, Ohio State University, Columbus

SMB FINANCIAL PLANNING

Date: **Friday, September 18**
Time: **1:30 pm-3 pm**

The instructional content includes the following outline:

A. The physician's relationship with outside advisors
B. The physician as the trustee and/or administrator of a retirement plan, including the importance of design and non-discriminatory administration
C. The legal machinery of a medical practice:
   1. Employment Agreements
   2. Salary Continuation Agreements
   3. Buy-sell Agreements
   4. Lease and Rent Documents
   5. Equipment Purchasing
D. Business Insurance
   1. Professional Liability
   2. Office Insurance, including contents, building, equipment and valuable papers, director's liability
   3. Business Overhead Insurance
   4. Buy-sell Insurance
   5. Health Insurance for employees and staff
   6. Disability Insurance
E. Business Form
   1. Sole Proprietor
   2. Partnership
   3. Corporate
      A. Regular corporation
      B. S Corporation
F. Office Building and Equipment
   1. Build or Rent
   2. Buy or Lease
G. Business Investments
   1. The medical corporation as an investment tool
   2. Business cash flow management
   3. Business long-term investment strategy
H. Retirement Plan Investments
   1. Long-Term Strategy
   2. Forms of Investment
I. Business Planning Meeting
   1. Periodic meeting with advisors
   2. Year End Meeting
J. Financial Analysis and Management Decisions
K. Business Tax Decision Making

The objectives of the symposium will be made known to the participants by specific decision models for the implementation of the symposium topics. An implementation discussion, including: 1. when to make the decision; 2. advisors required to implement; 3. duration of decision and implementation; 4. cost of implementation; and 5. future analysis to justify decision.

Speaker:

John E. Sestina, CFP, ChFC, SMB Financial Planning, Inc.

STROKE PROGRAM

Date: **Friday, September 18**
Time: **1:30 pm-5 pm**

Learner Objectives:

1. Understand the increasing evidence supporting an emergency approach to stroke therapy
2. Learn the limitations of the "traditional" therapeutic agents used for stroke intervention
3. Learn about tissue plasminogen activator, particularly with respect to its use in emergency stroke therapy
4. Learn about other new therapeutic agents which have recently been tested or are currently under study regarding safety and efficacy, in the setting of acute cerebral infarction
5. Learn about new studies defining the natural history of blood pressure elevations in the setting of acute cerebral infarction
6. Learn about state-of-the-art blood pressure management in the setting of acute cerebral infarction
7. Learn about the limitations of traditional therapies for hemorrhagic stroke
8. Learn about new treatments for intracerebral hemorrhage and subarachnoid hemorrhage
9. Learn about the sensitivity of magnetic resonance imaging in the setting of cerebrovascular disease
10. Learn about magnetic resonance imaging and problems of specificity in the setting of cerebrovascular disease
11. Learn about the latest studies of aspirin in the setting of acute cerebral infarction and in the setting of TIA, with attention to both low-dose and high-dose aspirin and with attention to the influence of patient gender

12. Learn about the strengths and weaknesses of non-invasive carotid artery evaluation methods
13. Learn about the recent developments in the management of asymptomatic carotid artery stenosis

Target Audience: Internists, Family Physicians, Surgeons and Vascular Surgeons, Neurosurgeons and Neurologists

Course Co-Directors: Drs. Thomas Brott, Cincinnati, and Anthony Furlan, Cleveland

Speakers:

Emergency Stroke Therapy Introduction — Making Every Minute Count: Thomas Brott, MD, assistant professor of neurology, University of Cincinnati College of Medicine

TPA (tissue plasminogen activator) and Other Emergency Therapies for Cerebral Infarction: Anthony Furlan, MD, director of Cerebrovascular Program, Cleveland Clinic Foundation

The ICU Approach to Anti-Hypertensive Rx and Other "Supportive" Therapies for Stroke: Dr. Brott

What's New in Treatment for Hemorrhagic Stroke (including subarachnoid hemorrhage): John Little, MD, head, Section of Cerebrovascular Surgery, Cleveland Clinic Foundation

Stroke Diagnosis and Prevention

What Do All Those MRI Abnormalities Mean? Donald Chakeres, MD, associate professor of radiology, Ohio State University College of Medicine

New and Old Anti-Platelet Agents — with new data from the UK on low-dose vs. high-dose ASA: Dr. Furlan

1987 and Asymptomatic Carotid Artery Stenosis — how accurate are the non-invasive tests and what should we do for the patient? Creighton B. Wright, MD, professor of clinical surgery, University of Cincinnati College of Medicine

UPDATE ON RHEUMATOLOGY

Date: **Saturday, September 19**
Time: **8:30 am-noon**

Presented by: Ohio Rheumatism Association: Three separate rheumatologic problems will be discussed with an emphasis on clinical features, management and research so that the participants can gain a better overall understanding of the problems.

This course is for the primary care physician or rheumatologist that evaluates and manages rheumatologic problems.

Course Director: Michael W. Lindamood, MD, Blanchard Valley Medical Associates, Findlay

Presiding: Stephen J. Farber, MD, Toledo Clinic, Toledo

Speakers:

Kathy Harmon, MD, Medical College of Ohio, Toledo

James Steigerwald, MD, Medical College of Ohio, Toledo

Kenneth D. Brandt, MD, Rheumatology Division, Indiana University School of Medicine

UPDATE ON THERAPY OF ISCHEMIC HEART DISEASE

Date: **Saturday, September 19**
Time: **1:30 pm-5 pm**

Course Director: Richard P. Lewis, MD, professor of medicine, Division of Cardiology, Ohio State University Department of Internal Medicine

Presiding: Dr. Lewis

Speakers:

Does Lowering Cholesterol Make a Difference?: Evan Stein, MD, associate professor of pathology and medicine, University of Cincinnati

Thrombolysis and Urgent Angioplasty for Acute Myocardial Infarction: Raymond Magorien, MD, associate professor of medicine, Ohio State University

Coronary Angioplasty Versus Coronary Artery Bypass for Stable Angina Pectoris: John Schneider, MD, associate professor of clinical medicine, University of Cincinnati

Beta Blocker Therapy for Ischemic Heart Disease: Richard P. Lewis, MD, professor of medicine, Division of Cardiology, The Ohio State University Department of Internal Medicine

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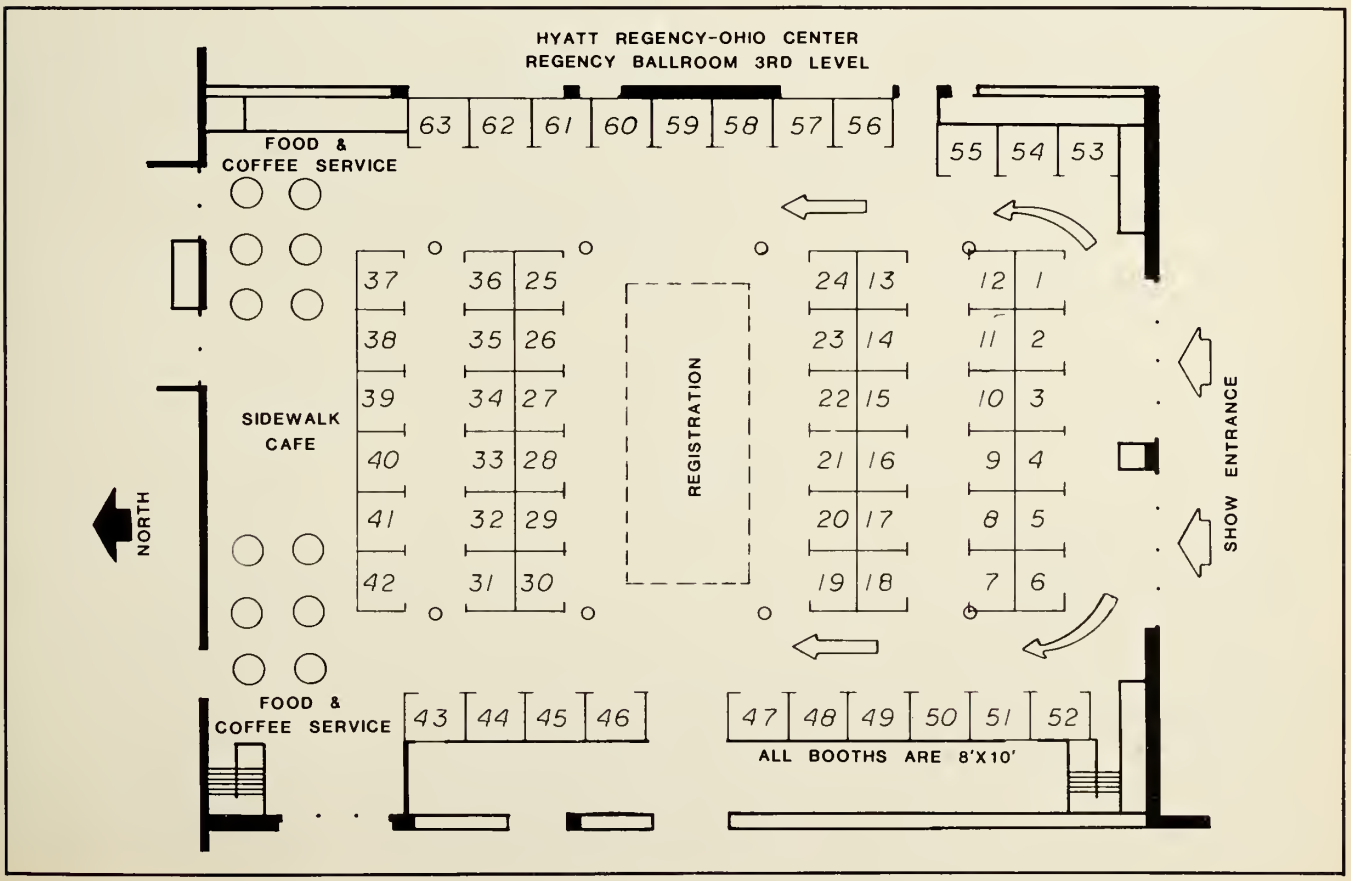
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CLINICAL
UPDATE

The Exhibitors . . .

NAME	BOOTH NO.
Physicians Insurance Company of Ohio	1
Ashley's Medical Interiors	2
Inter-Con Enterprises, Inc.	3
Ohio Association of Physician Assistants	4
CBS Computers, Inc.	5
Wallace Laboratories	6
Glaxo, Inc.	7
Lifeline of Ohio	8
Brentwood Instruments	12
Mount Carmel Health	13, 14 and 24
Abbott Laboratories	15
Community Mutual-Blue Cross/Blue Shield	16
Air Force Health Professions Recruiting	18
Office Management Systems, Inc.	19
Industrial Commission of Ohio	20
Central Pharmaceuticals, Inc.	21
Rainbow Tree Center, Inc.	22
Merck Sharp & Dohme	23
Immke Circle Leasing	25, 26, 27



1987 OSMA Annual Scientific Meeting
Hyatt Regency at Ohio Center, Columbus
September 18-20
Registration Form for Clinical Update

FRIDAY, SEPTEMBER 18
(8:30 am to noon, including break)
____ Plenary Session on AIDS **(3 hrs)**

FRIDAY, SEPTEMBER 18
(1:30 to 5 pm, including break)
____ Vascular Lab and the Primary Practice Physician **(3 hrs)**
____ Early Management of Stroke **(3 hrs)**
____ Geriatrics I — Interdisciplinary Approach **(3 hrs)**
____ Common Office Emergencies **(3 hrs)**

FRIDAY, SEPTEMBER 18
(1:30 to 3 pm)
____ Effective Use of the Physician Assistants **(1½ hrs)**
____ Sexually Transmitted Diseases **(1½ hrs)**
____ Ocular Manifestation of Systemic Disease **(1½ hrs)**
____ SMB Financial Planning **(1½ hrs)**

FRIDAY, SEPTEMBER 18
(3:30 to 5 pm)
____ Pediatric Eye **(1½ hrs)**
____ Orthopaedic Program **(1½ hrs)**
____ Effective Use of the Physician Assistants (repeated) **(1½ hrs)**
____ Examination for Sexual Abuse **(1½ hrs)**

SATURDAY, SEPTEMBER 19
(8:30 am to noon, including break)
____ Depression in the Primary Care Patient: Diagnosis and Improving Treatment of a Growing Problem **(3 hrs)**
____ Update on Rheumatology **(3 hrs)**
____ Management of Chronic Neck and Low Back Problems **(3 hrs)**
____ New Concepts in Plastic Surgery **(3 hrs)**
____ Initial Management of Trauma/Trauma Surgery **(3 hrs)**
____ Alternative Delivery Systems **(6 hrs) continued in afternoon**

SATURDAY, SEPTEMBER 19
(10:30 am to noon)
____ An ACLS and CPR Standards Update **(1½ hrs)**
____ Pigmented Lesion of Skin **(3 hrs) cont'd pm**

SATURDAY, SEPTEMBER 19
(1:30 to 5 pm, including break)
____ Geriatrics II — Overdose in the Elderly: An Interdisciplinary Concern **(3 hrs)**
____ Update on Therapy of Ischemic Heart Disease **(3 hrs)**

SATURDAY, SEPTEMBER 19
(1:30 to 3 pm)
____ Applications of Specialized Modern Diagnostic Imaging in Clinical Medicine **(1½ hrs)**
____ Pigmented Lesion of Skin **(cont'd)**

SATURDAY, SEPTEMBER 19
(3:30 to 5 pm)
____ Oncology Program **(1½ hrs)**

SUNDAY, SEPTEMBER 20
(8:30 am to noon, including break)
____ Critical Issues in Sports Medicine **(3 hrs)**
____ Geriatrics III — Nurses Program **(3 hrs)**
____ Conservative Management of Breast Cancer **(3 hrs)**
____ Vertigo, etc. **(3 hrs)**
____ Hypertension **(3 hrs)**

SUNDAY, SEPTEMBER 20
(8:30 to 10 am)
____ The Pharmacotherapeutic Approach to Allergy and Asthma **(1½ hrs)**

SUNDAY, SEPTEMBER 20
(10:30 am-noon)
____ Diabetic Eye **(1½ hrs)**

Name _____
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- Friday luncheon _____
- Saturday luncheon _____
- Indicate total number of credit hours:

_____ × $10 (members) $_____
_____ × $13 (non-members) $_____
_____ × $4 (residents) $_____
_____ × $7 (retired members) $_____
_____ × $3 (med. students) $_____
TOTAL $_____

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The Exhibitors . . . *continued*

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Janssen Pharmaceuticals	28
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Grant Laser Center	63

Exhibit schedule

Friday, September 18
6 am-9 am — exhibits set up
9:30 am-6 pm — exhibits open
Noon-1:30 pm — deli luncheon for participants in exhibit hall
5 pm-6 pm — reception

Saturday, September 19
7:30 am-6 pm — exhibits open
Noon-1:30 pm — deli luncheon for participants in exhibit hall
5 pm-6 pm — reception

Sunday, September 20
7:30 am-noon — exhibits open
Noon — exhibits move out (must be out by 5 pm)

Annual Meetings held in conjunction with OSMA's Clinical Update

The Ohio Ophthalmological Society Annual Meeting
Saturday, September 19
All day — 8:30 am-5 pm
Evening — Cocktails and dinner

Sunday, September 20
Half day — 8:30 am-noon

The Ohio State Neurosurgical Society Annual Meeting
Saturday, September 19
1:30 pm-5 pm
Evening — Cocktails and dinner

DELI LUNCHEON

Don't skip lunch, even if you are between seminars . . . A deli luncheon will be set up both Friday and Saturday in the exhibit hall. Come enjoy!

Scientific Session

Ohio State Neurosurgical Society

Saturday afternoon, September 19, 1987
Delaware B Room,
Hyatt Regency/Ohio Center
Columbus, Ohio

Symposium on Surgery for Epilepsy

Moderator:
Samuel H. Greenblatt, MD, Toledo

1:30-1:35 pm —
Introduction — Dr. Greenblatt

1:35-2:15 pm —
Advances in Case Selection Criteria in Relation to Outcome of Cortical Resection for Seizure Control — Mark Rayport, MD, PhD, Toledo, Ohio Neurosurgeon of the Year

2:15-2:55 pm —
Studies of Human Cortical Function in Surgery for Epilepsy — George A. Ojemann, MD, Seattle, Washington, Honored Guest

2:55-3:35 pm —
Neuropsychiatric Studies of Human Limbic Function in Surgery for Epilepsy — Shirley M. Ferguson, MD, Toledo

3:35-3:45 pm —
Discussion

3:45-4 pm —
Coffee Break

4-4:05 pm —
Introduction of Subsession on Corpus Callosum — Dr. Greenblatt

4:05-4:25 pm —
Indications for Callosal Section for Seizure Control — Dennis D. Spencer, MD, New Haven, Connecticut

4:25-4:45 pm —
Outcomes of Corpus Callosum Section: Seizure Control and Behavior — Dr. Rayport

4:45-5 pm —
Concluding discussion

Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

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The Official Minutes of the 1987 OSMA House of Delegates

Index to Actions on Resolutions

Editor's Note: Report of Resolutions Committee No. 1 begins on page 543, Resolutions Committee No. 2 on page 547, Resolutions Committee No. 3 on page 549. This index is for reference purposes and is not part of the Official Proceedings of the 1987 House of Delegates.

Resolution No. . . .	Subject and Sponsor	Referred to Resolutions Com.
00-87	Establishment of a Resident Physicians' Section Within the OSMA (By OSMA Council)	1
01-87	Medical Specialty Society Representation (By Ohio Academy of Family Physicians)	1
02-87	Specialty Society Representation (By William F. Ruschhaupt, MD, Cleveland)	1
03-87	Medical Specialty Society Representation (By Ohio Chapter, American College of Emergency Physicians)	1
04-87	Spouse Active Membership (By Ohio State Medical Association Council)	1
05-87	Multi-County Membership (By Ohio State Medical Association Council)	1
06-87 to Am. 06-87	Study of Alternative Structures (By Medina County Medical Society)	1
07-87 to Sub. 07-87	Physician Inclusion in Medicare DRG Program (By First District Delegation)	1
08-87 (replaced by Sub. 07-87)	OSRS Supports AMA Resolution 30 (By Ohio State Radiological Society)	1
09-87 (replaced by Sub. 07-87)	Physician DRG (By Academy of Medicine of Columbus and Franklin County, Academy of Medicine of Toledo and Lucas County)	1
10-87 to Am. 10-87	Second Opinion Plans (By Ross County Medical Society)	1
11-87 to Am. 11-87	Patient Care Concerns (By Fifth District Delegation)	1
12-87 to Am. 12-87	Standardized Insurance Forms (By Stark County Medical Society)	1
13-87	CON Legislation (By Stark County Medical Society)	1
14-87 to Am. 14-87	Opposition to Government Legislated Physician Fee Controls and Services Under Medicare (By Montgomery County Medical Society)	1
15-87	Assignment of Health Insurance Benefits (By Fifth District Delegation)	1

16-87 to Sub. 16-87	Catastrophic Health Insurance (By Huron County Medical Society)	1
17-87	Ohio State Medical Association Statewide PPO (By Butler County Medical Society)	1
18-87	Enrollment as Providers in Third Party Payment Plans (By Council of Summit County Medical Society)	1
19-87	Restore Private Ethical Medical Practice (By Huron County Medical Society)	1
20-87	Curtail "Fair Fee Support" Language (By Montgomery County Medical Society)	1
21-87	Annual Meeting (By Council of Summit County Medical Society)	2
22-87	Swift Communication (By Huron County Medical Society)	2
23-87	OMPAC (By Fifth District Delegation)	2
24-87	AMA Representation (By Council of Summit County Medical Society)	2
25-87	Women in Medicine Committees (By First District Delegation)	2
26-87 to Am. 26-87	Medical Staff Bylaws (By Council of Summit County Medical Society)	2
27-87	Risk Pooling (By Fifth District Delegation)	2
28-87	The Hospital Medical Staff Independent Practice Corporation Concept (IPCC) (By Fifth District Delegation)	2
29-87	Peer Review of the Performance of Hospital Medical Staff Physicians (By Fifth District Delegation)	2
30-87	Establishment of a Special Task Force for Foreign Medical Graduates (By Fifth District Delegation)	2
31-87	Fee Review by the Ohio State Medical Board (By Fifth District Delegation)	2
32-87 to Sub. 32-87	Opposition to Usage of Sl Nomenclature (By Fifth District Delegation)	2
33-87 (replaced by Sub. 33-87)	HB 150 Constitutional Malpractice (By Huron County Medical Society)	2
34-87	Patient Compensation Fund (By W.W. Tuckerman, MD)	2
35-87 to Sub. 35-87	Hospital Advertising (By Paul S. Metzger, MD)	3
36-87 to Sub. 36-87	Clinical Laboratory Certification (By Stark County Medical Society)	2
37-87 (replaced by Sub. 33-87)	Mandatory Medicare Assignment for Medical Licensure in the State of Ohio (By Stark County Medical Society)	2
38-87	Triage of Accident and Trauma Victims (By Stark County Medical Society)	2
39-87 (replaced by Sub. 33-87)	Mandatory Medicare Assignment for Licensure or Relicensure (By First District Delegation)	2
Report A	Policies to be Retained — 1983 House of Delegates Proceedings	2
40-87 to Am. 40-87	AIDS Campaign (By Fifth District Delegation)	3
41-87	Health Education on AIDS in Public Schools (By Fifth District Delegation)	3
42-87	Community Liaison Regarding AIDS (By OSMA Task Force on AIDS Discrimination)	3
43-87	Alcohol Treatment (By Academy of Medicine of Toledo and Lucas County)	3
44-87	Reaffirmation of Resolution No. 58-84: Public Purchase and Consumption of Alcoholic Beverages	3

	(By Academy of Medicine of Columbus and Franklin County)	
45-87	Mail Order Prescriptions (By Council of Summit County Medical Society)	3
46-87 to Am. 46-87	Office Dispensing of Prescription Drugs (By First District Delegation)	3
47-87	Third Party Interference with Physician Prescribing Patterns (By Montgomery County Medical Society)	3
48-87 to Sub. 48-87	Labeling of Generic Substitutions (By OSMA Medical Student Section)	3
49-87	Parking for Temporarily Handicapped (By Sixth District Delegation)	3
50-87	Bedside Blood Glucose Monitoring in Hospitalized Diabetic Patients (By Janet K. Bixel, MD)	3
51-87 to Am. 51-87	Statewide Ethics Committee (By First District Delegation)	3
52-87	Reaffirmation of Resolution No. 46-84: Mandatory Use of Protective Helmets for Motorcyclists (By Academy of Medicine of Columbus and Franklin County)	3
53-87	Civil Aeromedical Helicopter Industry Safety (By OSMA Medical Student Section)	3
54-87	Continual Medical and Patient Education Socio-Political Economic Topics (By Huron County Medical Society)	3
55-87 to Am. 55-87	Early Detection (By Fifth District Delegation)	3
56-87 (replaced by Sub. 35-87)	OSMA Policy on Advertising (By OSMA Medical Student Section)	3
57-87 to Am. 57-87	Student-to-Student Community Health Education Project (By OSMA Medical Student Section)	3
58-87	Smoke-Free Environment (By Academy of Medicine of Columbus and Franklin County)	3
	President's Address	3

Physician image — it's still better in your office

Wonder how your public image is doing? According to the AMA's 1987 Survey of Physician and Public Opinion, you're not faring as well as you did in 1985 when this question was last included, but, on the other hand, your public image may be better than you think it is.

For example, 63% believe that most doctors take a genuine interest in their patients; 61% feel that doctors are usually up-to-date on the latest advances in medicine; and almost half (45%) agree that doctors usually explain things well to their patients — a sentiment, incidentally, that has increased a whole percentage point since 1985. On a more negative note, however, a majority of the public still believe that doctors keep patients waiting too long (69%); are too quick to prescribe drugs when other kinds of treatment might be useful (58%); and are too interested in making money (56%). And only 36% believe most doctors spend enough time with their patients.

On the other hand, most people are still extremely happy with their own physician. In a question which asked respondents to "think back to their most recent visit to a doctor," 93% expressed satisfaction with the way the doctor's staff treated them; 92% were pleased with the medical care they received; 87%



approved of the way the doctor explained things to them; 77% had no objection to the time it took to see the doctor; 74% had no problem with the fee; and overall, 91% of the respondents indicated they were satisfied with the visit.

The 1987 Annual Meeting Proceedings of the OSMA House of Delegates

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7:10 pm, Friday, May 15, 1987, at the Regency Ballroom, Ohio Center, Columbus, with the President, John E. Albers, MD, presiding.

Dr. Albers announced the Presentation of the Colors by the 2291st U.S. Army Hospital Color Guard, followed by the Pledge of Allegiance. Dr. Albers thanked the 2291st U.S. Army Hospital Color Guard for its participation.

The invocation was offered by William J. Marshall, MD, Dayton, Second District Councilor and past deacon, Westminster Presbyterian Church.

Dr. Albers introduced others seated at the Speakers Table, as follows: Joseph Sudimack, Jr., MD, Warren, Secretary-Treasurer; Herman I. Abromowitz, MD, Dayton, Immediate Past President; W.J. Lewis, MD, Dayton, OSMA Parliamentarian; D. Brent Mulgrew, JD, Managing Director; Herbert E. Gillen, Executive Director; D. Ross Irons, MD, Bellevue, President-Elect; Dr. William J. Marshall, Dayton (already introduced) and William A. Millhon, MD, Columbus, President of the Academy of Medicine of Columbus and Franklin County.

Dr. Millhon welcomed the delegates, alternates and guests to Columbus on behalf of the Academy of Medicine of Columbus.

Report of the Credentials Committee

Luther W. High, MD, Millersburg, Chairman of the Credentials Committee reported that of 251 members eligible to attend and vote, 171 were present.

A number of alternate delegates, guests, officers of county medical societies, and medical society executives were in attendance.

1986 Minutes Approved

The minutes of the 1986 sessions of the House of Delegates, as published in the August 1986 issue of *The Ohio State Medical Journal* were approved.

Introduction of Member, AMA Board of Trustees

Dr. Albers introduced Ray W. Gifford, Jr., MD, Cleveland, a member of the AMA Board of Trustees. Dr. Gifford addressed the House, thanking the Ohio delegation for its support.

Dr. Albers introduced John E. Kasper, an AMA Field Representative.

Introduction of Out-Of-State Presidents

Dr. Albers introduced the following out-of-state presidents: Shirley T. Khalouf, MD, Marion, Indiana, President, Indiana State Medical Association, and Herbert Khalouf, MD; Frederick Bryant, MD, Royal Oak, Michigan, President-Elect, Michigan State Medical Society; R. Robert Tyson, MD, Rome, Pennsylvania, President, Pennsylvania Medical Society and Mrs. Tyson; Cordell A. DeLaPena, MD, Clarksburg, West Virginia, President-Elect, West Virginia State Medical Association, and Erlinda DeLaPena, MD.

Introduction of OSMA Past Presidents

Dr. Albers introduced the following Past Presidents of the Association: John Budd, MD, Cleveland (Honorary Past President); Charles L. Hudson, MD, Cleveland (both Drs. Budd and Hudson are AMA Past Presidents); Robert N. Smith, MD, Toledo; Oscar W. Clarke, MD, Gallipolis; James L. Henry, MD, Grove City; John J. Gaughan, MD, Cleveland; Thomas W. Morgan, MD, Gallipolis; Robert G. Thomas, MD, Elyria; Stewart B. Dunsker, MD, Cincinnati; S. Baird Pfahl, Jr., MD, Sandusky; A. Burton Payne, MD, Ironton;

and Dr. Herman I. Abromowitz, Dayton.

Introduction of Past Members of the OSMA Council

Dr. Albers then introduced former members of the Council: David A. Barr, MD, Lima; Theodore J. Castele, MD, Cleveland; William Dorner, Jr., MD, Akron; D. James Hickson, MD, Mt. Gilead; Stephen P. Hogg, MD, Cincinnati; Edward G. Kilroy, MD, Cleveland; W.J. Lewis, MD, Dayton; and J. Hutchison Williams, MD, Columbus.

At this time Dr. Albers also introduced Hart F. Page, CAE, OSMA's Executive Director Emeritus.

Introduction of Representatives of Allied Organizations

Dr. Albers introduced various representatives from the allied organizations: Robert C. Hinkle, DDS, Columbus, President-Elect, Ohio Dental Association, and Mrs. Hinkle; William J. Stefanich, DO, Newark, President, Ohio Osteopathic Association, and Mrs. Stefanich; Duke Thomas, JD, Columbus, Past President, Ohio State Bar Association, and Mrs. Thomas; Mary Beth Strauss, RN, Columbus, President, Ohio Nurses Association; Doris Hirchak, Maple Heights, President, Ohio State Society of Medical Assistants; Ann Bauer, LPN, Executive Director, Licensed Practical Nurses Association of Ohio; Joyce Johnson, Columbus, President, OSMA Auxiliary, and Owen Johnson, MD.

Membership Outreach Program

Dr. Thomas W. Morgan, Gallipolis, Chairman of the OSMA Membership Committee, presented the results of Ohio's Physician Outreach Program — 1986 and announced counties where 100% membership was reached. He also mentioned that more work on recruiting and obtaining new members will be initiated and urged members present to pick up brochures before leaving.

Introduction of OSMA Auxiliary President

Nora Feezel, Canton, Immediate Past President of the Ohio State Medical Association Auxiliary, was escorted to the rostrum by Edward E. Grable, MD. She addressed the House of Delegates and reported on 1986-1987 activities of the Auxiliary.

Presentation of AMA-ERF Checks

Dr. Albers, assisted by Mrs. Feezel, then presented checks to the representatives of the following Ohio medical schools: Case Western Reserve University School of Medicine, Cleveland; University of Cincinnati College of Medicine, Cincinnati; The Ohio State University College of Medicine, Columbus; Medical College of Ohio at Toledo; Northeastern Ohio Universities College of Medicine, Rootstown and Wright State University School of Medicine, Dayton. Contributions to Ohio's six medical schools totaled $97,569.68.

Presentation of Plaques to Retiring Members of the Council

The following members of the Council received plaques in appreciation for their service to the Association as members of the Council: Dr. Herman I. Abromowitz, Dayton; Joseph L. Kloss, MD, Akron, and Brian Jewell, Toledo.

Presentation of Plaques to Retiring Members of the Ohio Delegation to the AMA

The following retiring members of the Ohio Delegation to the AMA received plaques in appreciation for their service: Dr. Ray W. Gifford, Jr., Cleveland; Jack Schreiber, MD, Canfield; Robert N. Smith, MD, Toledo. Carl E. Spragg, MD, New Concord and Joel Gelman, MD, Toledo, received awards in absentia.

Certificates of Appreciation

Dr. Albers then made announcement of the retiring members of Standing Committees and Chairmen of Special Committees as follows: Donavin A. Baumgartner, Jr., MD, Cleveland, Chairman, Committee on Auditing and Appropriations; Nermin D. Lavapies, MD, Martins Ferry, Chairman, Auxiliary Advisory Ad Hoc Committee; J. James Anderson, MD, Youngstown, Advisor, Medical Assistants; James C. McLarnan, MD, Mt. Vernon, Chairman, Ad Hoc Committee to Review House of Delegates Policy; Charles H. McMullen, MD, Loudonville, Chairman, Committee on Public and School Health (in absentia); Warren Ljungren, MD, Dayton, Chairman, Resident Physicians Committee; James J. Augustine, MD, West Carrollton, Vice Chairman, Resident Physicans Committee; Dr. William J. Marshall, Dayton, Chairman, Committee on State Legislation; Howard S. Madigan, MD, Toledo, Member, Committee on Accreditation; Stella Brown, Dayton, Member, Committee on Communications; Frederic C. Henry, MD, Toledo, Member, Committee on Judicial and Professional Relations; Felipe V. Lavapies, MD, Tiltonsville, Member, Committee on Judicial and Professional Relations; A. Robert Davies, MD, Troy, Member, Committee on Membership; Dr. William Dorner, Jr., Akron, Member, Committee on Membership and Joyce Johnson, Columbus, Member, Committee on Membership. Dr. Albers advised that they would receive their certificates of appreciation in the

mail following the Annual Meeting.

Reference Committee Chairmen Announced

The following House of Delegates Reference Committee chairmen were introduced by President Albers: Credentials of Delegates — Dr. Luther W. High, Holmes County — Tellers and Judges of Election — Claire V. Wolfe, MD, Franklin County; Resolutions Committee No. 1 — Dr. Owen E. Johnson, Franklin County; Resolutions Committee No. 2 — Dr. William Dorner, Jr., Summit County; Resolutions Committee No. 3 and President's Address — Daniel E. Santos, MD, Hamilton County.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: First District — Lee Vesper, MD, Hamilton County; Second District — Jerry L. Hammon, MD, Miami County; Third District — James A. Murray, MD, Seneca County; Fourth District — Dr. Howard S. Madigan, Lucas County; Fifth District — Dr. John J. Gaughan, Cuyahoga County; Sixth District — Robert C. Reed, MD, Stark County; Seventh District — Ronald C. Agresta, MD, Jefferson County; Eighth District — James R. Gaskell, MD, Athens County; Ninth District — Thomas P. Price, Jr., MD, Gallia County; Tenth District — Dr. William A. Millhon, Franklin County; Eleventh District — Charles J. Everett, MD, Erie County; Twelfth District — Francis J. Waickman, MD, Summit County.

Dr. Albers announced that under the system of rotation approved by the House of Delegates in 1963, the Chairman of the Committee this year would be the delegate from the Second District, Dr. Jerry L. Hammon, Miami County.

Medicaid Drug Formulary

Janet K. Bixel, MD, Columbus, came forward to present a report of the OSMA Representatives to the Ohio Medicaid Drug Formulary Advisory Committee.

President's Address

Herbert E. Gillen, Executive Director, OSMA, introduced Dr. John E. Albers, who announced that a slide presentation prepared by the OSMA Department of Communications would be presented after which he would make remarks.

Upon completion of the presentation of the address, Dr. Albers received a standing ovation.

Memorial Resolutions Introduced

The following Memorial Resolutions were presented to the House:

C. Douglass Ford, MD

Read by John A. Devany, MD, Lucas County, Fourth District Councilor

WHEREAS, C. Douglass Ford, MD, born in Columbus, Ohio, December 6, 1923, served with distinction and honor as President of the Ohio State Medical Association in 1982-1983; and

WHEREAS, Dr. Ford was Councilor of the Fourth District from 1975-1981; and

WHEREAS, Dr. Ford served as Councilor of the Academy of Medicine of Toledo and Lucas County from 1968-1970 and served on many Academy committees; and

WHEREAS, Dr. Ford admirably served in the Ohio State Medical Association House of Delegates from 1968-1975; and

WHEREAS, Dr. Ford served on the Ohio Delegation to the American Medical Association from 1977-1986; and

WHEREAS, Dr. Ford served the public faithfully and well during his years as a physician; and

WHEREAS, Dr. Ford, after his long and distinguished career, died July 20, 1986; and

WHEREAS, His warmth, compassion and humor will be sadly missed by his colleagues; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association record its admiration and appreciation for Dr. Ford's many contributions to his community, his patients and his profession; and, be it further

RESOLVED, That the Ohio State Medical Association convey its respect and sympathy to his wife Betsy, and to his family.

Merrill D. Prugh, MD

Read by Dr. William J. Marshall, Montgomery County, Second District Councilor

WHEREAS, Merrill D. Prugh, MD, born in Preble County, Ohio, February 21, 1884, served as President of the Ohio State Medical Association, 1954-1955; and

WHEREAS, Dr. Prugh served as Delegate to the Ohio State Medical Association, 1944-1949; and

WHEREAS, Dr. Prugh served as Councilor of the Second District from 1949-1953; and

WHEREAS, Dr. Prugh served as President of the Montgomery County Medical Society, 1941; and

WHEREAS, Dr. Prugh exemplified the highest traditions of the medical profession during his 56 years of practice; and

WHEREAS, Dr. Prugh, after his long and distinguished career, died on May 23, 1986; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association recognizes the contribution Dr. Prugh has made to the profession of medicine, and observes with sadness the death of this vigorous and accomplished colleague; and, be it further

RESOLVED, That a copy of this resolution with an expression of

our sympathy forwarded to Mr. Dan Prugh.

Frederick Taylor Merchant, MD

Read by Thomas R. Leech, MD, Allen County, Third District Councilor

WHEREAS, Frederick Taylor Merchant, MD, honored the medical profession in the State of Ohio and in the United States of America by his distinguished activity in medicine over a period of three decades; and

WHEREAS, Dr. Merchant rendered outstanding service in the performance of his duties as Member of the Ohio Medical Board of Ohio (1957 to 1971), and as President of the State Medical Board of Ohio in the years 1963 and 1969; and

WHEREAS, Dr. Merchant, through his leadership in the Federation of State Medical Boards of the United States, as Director (1966 to 1971), President (1970), and as Chairman, Executive Director, and Secretary of the FLEX Board, has shown diligent dedication to the highest standards of physician evaluation, which has resulted in the nationwide acceptance of a uniform state licensure examination; and

WHEREAS, Dr. Merchant served on the test committee of the Educational Council for Foreign Medical Graduates (ECFMG) from 1977 to 1985, and on the Medical Skills Committee of the ECFMG from 1982 to 1985; and

WHEREAS, Dr. Merchant has faithfully served the citizens of the State of Ohio by his active involvement in civic causes such as United Way, United Appeal, the Marion Cancer Detection Clinic (Director, 1946 to 1964), the Marion Board of Health (1947 to 1962), the Marion Health Foundation (Medical Director, 1978 to 1982), Marion County Tuberculosis Association (Chairman), and Reyes Foundation for Pre-Medical Education at Ohio Wesleyan College; and

WHEREAS, Dr. Merchant was awarded many honors by the Federation of State Medical Boards of the United States, including a citation for distinguished service to the Federation for two decades, a plaque of appreciation for service on the FLEX Board, and the Federation's First Annual Distinguished Service Award; therefore be it

RESOLVED, That the Ohio State Medical Association recognizes Frederick Taylor Merchant, MD for his very distinguished service, steadfast purpose, outstanding wisdom, and leadership in the cause of excellence, and for his faithful and excellent service to the medical profession, the Association, the Ohio State Medical Board, the Federation of State Medical Boards of the United States, and the State of Ohio.

Charles H. McMullen, MD

Read by Charles G. Adams, MD, Lorain County, Eleventh District Councilor

WHEREAS, Charles H. McMullen, MD, of Loudonville, Ohio served faithfully and well during this 36 years as a physician; and

WHEREAS, Dr. McMullen served for more than 25 years as Chairman of the OSMA Committee on School Health — winning highest respect from his peers for outstanding leadership, including development of OSMA policy supporting comprehensive health education from kindergarten through the 12th grade in Ohio schools; and

WHEREAS, Dr. McMullen's accomplishments were recognized nationally — resulting in his appointment and subsequent service on the American Medical Association-National Education Association Joint Committee; and

WHEREAS, In 1960, Dr. McMullen was one of the founders and a charter member of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association; and

WHEREAS, In recognition of his service to the Boy Scouts of America as a member of the executive board of the Johnny Appleseed Council, he was presented the Silver Beaver Award, scouting's highest award for an adult; and

WHEREAS, Dr. McMullen was a past president of the local board of education and also active in the First Presbyterian Church and Rotary Club; and

WHEREAS, Dr. McMullen's compassion for his family, his patients, and his many friends from near and far was the primary quality that made him an ideal family physician; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association honor the contributions that this vigorous, accomplished, and caring colleague made to the profession of medicine and his community; and, be it further

RESOLVED, That a copy of this resolution with an expression of our sympathy be forwarded to Mrs. Mary Ellen McMullen, daughters Mrs. William (Pam) Beachler and Cynthia McMullen, and son John.

Harve M. Clodfelter, MD

Read by H. William Porterfield, MD, Tenth District Councilor

WHEREAS, Harve M. Clodfelter, MD, of Columbus, served as President of the Ohio State Medical Association in 1952-53; and

WHEREAS, Dr. Clodfelter served as President of the Columbus Academy of Medicine; and

WHEREAS, he was a senior attending physician at Mt. Carmel and Grant Hospitals and an assistant professor of medicine at the OSU College of Medicine; and

WHEREAS, Dr. Clodfelter was

one of the founders of the Central Ohio Heart Association and a member of the Columbus Society of Internal Medicine; and

WHEREAS, his career in the military included service as Commander of the USNR Medical Corp. in WWII; and

WHEREAS, Dr. Clodfelter was on President Eisenhower's Commission on Aging; and

WHEREAS, Dr. Clodfelter died April 1, 1987, after this distinguished career; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association observes in sadness the death of Dr. Clodfelter and recognizes his many contributions; and, be it further

RESOLVED, That a copy of this resolution with our sympathies be forwarded to the Clodfelter family and that a memorial resolution be introduced by the Ohio Delegation at the Annual Meeting of the American Medical Association House of Delegates.

Dr. Albers then asked permission of the House for immediate action on the five resolutions without referral and the resolutions were adopted by the House.

Introduction of Resolutions

Dr. Albers announced that because the resolutions had been printed and distributed to the members of the House prior to the meeting and the assignment of resolutions to the Resolutions Committee had also been presented to the House in writing, individual introduction of the resolutions would be waived unless there were objections voiced by the House. There were none and the reading of the resolutions was waived.

Committee on Emergency Resolutions Report

Dr. Albers announced that no emergency resolutions were submitted.

Action Report on 1986 Resolutions

Dr. Albers announced that a report on the "follow-up" work on 1986 resolutions was given to all Delegates and Alternate Delegates in their handbook — Action Report on 1986 Resolutions.

House Recessed

The House then recessed until the final session, 1 pm, Sunday, May 17, 1987.

Minutes of the Final Session

The final session of the House of Delegates was convened at 1:05 pm. Dr. Albers called the meeting to order.

Report of the Credentials Committee

Dr. Luther W. High, Holmes County, Chairman of the Credentials Committee, reported that out of 251 delegates eligible to vote, 216 were present, credentialed and seated.

Election of President-Elect

Dr. Albers called for nominations for the office of President-Elect. Dr. Thomas W. Morgan, Gallipolis, placed in nomination Dr. Donavin A. Baumgartner, Jr., Cuyahoga County, Councilor of the Fifth District. The nomination was seconded by Dr. John J. Gaughan, Cleveland. There were no other nominations and Dr. Baumgartner was elected by acclamation. Dr. Baumgartner briefly addressed the House and expressed his thanks to the House. He was seated at the head table.

Report of the Nominating Committee

Dr. Jerry L. Hammon, Delegate, Miami County, Chairman of the Nominating Committee, presented the report of the Committee on Nominations as follows:

Councilors

Fifth District: As Councilor of the Fifth District, to fill the unexpired one-year term of Dr. Donavin A. Baumgartner, Jr., Cleveland, the Committee placed in nomination Henry G. Krueger, MD, Cleveland. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Henry G. Krueger was declared elected Councilor of the Fifth District for a term of one year, 1987-1988.

Second District: As Councilor of the Second District, to succeed himself, Dr. William J. Marshall, Dayton, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Marshall was declared re-elected Councilor of the Second District for a term of two years, 1987-1989.

Fourth District: As Councilor of the Fourth District, to succeed himself, Dr. John A. Devany, Toledo, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Devany was re-elected Councilor of the Fourth District for a term of two years, 1987-1989.

Sixth District: As Councilor of the Sixth District, to succeed himself, Dr. J. James Anderson, Youngstown, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Anderson was re-elected Councilor of the Sixth District for a term of two years, 1987-1989.

Eighth District: As Councilor of the Eighth District, to succeed himself, Dr. John F. Kroner, Jr., Athens, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Kroner was re-elected Councilor of the Eighth District for a term of two years, 1987-1989.

Tenth District: As Councilor of the Tenth District, to succeed himself, Dr. H. William Porterfield, Columbus, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Porterfield was re-elected Councilor of the Tenth District for a term of two years, 1987-1989.

Twelfth District: As Councilor of the Twelfth District, to succeed Dr. Joseph L. Kloss, Akron, the Committee placed in nomination Jack L. Summers, MD, Tallmadge. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Jack L. Summers was declared elected Councilor of the Twelfth District for a term of two years, 1987-1989.

AMA Delegates

Dr. Hammon then presented the nominees for the office of Delegate to the American Medical Association to serve a term beginning May 17, 1987 and ending December 31, 1987 (two to be elected): Drs. David A. Barr, Lima; A. Robert Davies, Troy; John A. Devany, Toledo; Edward G. Kilroy, Cleveland; and Claire V. Wolfe, Dublin. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Davies and Wolfe were declared elected.

For Delegate to the American Medical Association to serve a term commencing January 1, 1988 and ending December 31, 1989, the following were nominated (nine to be elected): Drs. John E. Albers, Cincinnati; David A. Barr, Lima; Oscar W. Clarke, Gallipolis; A. Robert Davies, Troy; John A. Devany, Toledo; Alford C. Diller, Van Wert; William Dorner, Jr., Akron; John J. Gaughan, Cleveland; B. Leslie Huffman, Maumee; Edward G. Kilroy, Cleveland; Joseph Sudimack, Jr., Columbus; and Claire V. Wolfe, Dublin. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Albers, Clarke, Davies, Dorner, Gaughan, Huffman, Kilroy, Sudimack and Wolfe were declared elected.

For Delegate to the American Medical Association to serve a term commencing May 17, 1987 and ending December 31, 1988, the following were nominated (two to be elected): Drs. David A. Barr, Lima; John A. Devany, Toledo; Alford C. Diller, Van Wert, Stanley J. Lucas, Cincinnati; and Richard J. Nowak, Cleveland. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Lucas and Nowak were declared elected.

AMA Alternate Delegate

The OSMA Council and the Nominating Committee recommended to the House of Delegates that OSMA's total complement of Alternate Delegates be set at 16 rather than 18. The reasons for this recommendation are: (1) to comply with the 1987 budget that funds a total Delegation of 34; and (2) to allow for a convenient and simplified method of reducing the Delegate allocation in 1988 if certain membership criteria are not met.

A vote was taken and the House concurred with this recommendation.

It was announced that Stephen Gilreath, Cincinnati, was elected by the OSMA Medical Student Section as an Alternate Delegate for one year commencing February 28, 1987, in accordance with Chapter 5, Section 7 of the OSMA Bylaws.

For Alternate Delegate to the American Medical Association for a term commencing May 17, 1987 and ending December 31, 1987, the following were nominated (two to be elected): Drs. Louis L. Barich, Hamilton; Richard B. Fratianne, Cleveland; D. Ross Irons, Bellevue; Owen E. Johnson, Columbus; Jerome Kimmelman, Toledo, Thomas R. Leech, Lima; Robert J. McDevitt, Cincinnati; Raymond J. McMahon, Jr., Massillon; Walter A. Reiling, Jr., Dayton; Jack L. Summers, Tallmadge; Lance A. Talmage, Toledo; and Richard J. Wiseley, Toledo. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Irons and Summers were declared elected.

For Alternate Delegate to the American Medical Association to serve a term commencing January 1, 1988 and ending December 31, 1989, the following were nominated (seven to be elected): Drs. Louis L. Barich, Hamilton; David A. Barr, Lima; Donavin A. Baumgartner, Jr., Cleveland; John A. Devany, Toledo; Richard B. Fratianne, Cleveland; D. Ross Irons, Bellevue; Owen E. Johnson, Columbus; Jerome Kimmelman, Toledo; Thomas R. Leech, Lima; Robert J. McDevitt, Cincinnati; Raymond J. McMahon, Jr., Massillon; William T. Paul, Columbus; Walter A. Reiling, Jr., Dayton; Jack L. Summers, Tallmadge; Lance A. Talmage, Toledo; J. Hutchison Williams,

Columbus; and Richard J. Wiseley, Toledo. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Baumgartner, Devany, Irons, Johnson, Paul, Summers and Williams were declared elected.

For Alternate Delegate to the American Medical Association to serve a term commencing May 17, 1987 and ending December 31, 1988, the following were nominated (three to be elected): Drs. Louis L. Barich, Hamilton; Richard B. Fratianne, Cleveland; Jerome Kimmelman, Toledo; Thomas R. Leech, Lima; Raymond C. McMahon, Jr., Massillon; Walter A. Reiling, Jr., Dayton; Lance A. Talmage, Toledo; and Richard J. Wiseley, Toledo. A written ballot was taken and Drs. Kimmelman, McMahon and Reiling were declared elected.

Report of Resolutions Committee No. 1

Dr. Owen E. Johnson, Franklin County, as Chairman, presented the report of Resolutions Committee No. 1:

Reference Committee 1 gave careful consideration to the several items referred to it.

RESOLUTION NO. 00-87 Establishment of a Resident Physicians' Section Within the OSMA

RESOLVED, That a Resident Physicians' Section within the OSMA be formed to provide a forum within the state association for the exchange of information among young physicians in training and their senior colleagues; and, be it further

RESOLVED, That Article IV of the OSMA Constitution be amended by inserting a new part (4) as follows:

The House of Delegates shall be the legislative body of this Association and shall consist of: (1) delegates elected by the component societies; (2) officers of the Association enumerated in Article VI; (3) such representatives of other medical groups as may be determined by the House of Delegates; The Medical Student Section shall have six representatives to the House of Delegates commencing with the Annual Meeting in 1982, said delegates to be selected in accordance with the Bylaws of the Medical Student Section to be approved by Council.

For purposes of representation in the House of Delegates, student members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the student members of each medical school elect their own delegate; the Hospital Medical Staff Section shall have one representative to the House of Delegates commencing with the Annual Meeting in 1985, said delegate to be selected in accordance with bylaws of the Medical Staff Section to be approved by Council; (4) the resident physicians' section shall have one representative who must be a member in training of the OSMA, said representative to be selected in accordance with the residence section bylaws to be approved by council; (5) delegates and alternate delegates to the American Medical Association from Ohio, Past Presidents and Past Councilors of this Association, each of whom shall be an ex-officio member without right to vote unless such delegate, alternate delegate or past president be a duly elected delegate from a component society or a duly elected officer of this Association; and, be it further

RESOLVED, That Chapter 4 of the Bylaws be amended by inserting a new Section 4 as follows: Section 4: *Resident Section* The Resident Section shall have one delegate and one alternate delegate who must be members in training of the OSMA. The resident physician section's delegate shall have all the rights, privileges, and duties of other delegates. The delegate will be seated in the House of Delegates with councilor district in which his/her county medical society is represented (and renumber the remaining sections).

5. Representative of Hospital Medical Staff Section.
6. Quorum.
7. Committees of the House of Delegates.
8. Delegates to the American Medical Association.
9. Councilor Districts.
10. Special Committees.
11. Resolutions.
12. Order of Business.; and, be it further

RESOLVED, That the OSMA Constitution, Article VII, be amended as follows:

The Council shall consist of one Councilor from each Councilor district, one non-voting Councilor from the resident physicians' section, one non-voting student member from the Medical Student Section and the other elected officers of this Association. The Council shall be the executive body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates; and, be it further

RESOLVED, That the OSMA Bylaws Chapter 7, Section 4, (''Individual Duties of Councilors'') shall be amended as follows:

Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purposes of

inquiring into the condition of the profession and of each component society in his district and of keeping in touch with the activities of each of such societies.

In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics. The duties of the non-voting Councilor from the Medical Student Section shall be set forth in the Bylaws of said section. The duties of the councilor from the resident physicians' section shall be set forth in the bylaws of said section which shall be approved by council.

By official action, **the House voted to adopt Resolution No. 00-87.**

RESOLUTION NO. 01-87
Medical Specialty Society Representation

RESOLVED, That the Bylaws of the Ohio State Medical Association be amended to provide Medical Specialty representation in the House of Delegates as follows:

Chapter 4: The House of Delegates

Section 3: Representation of Medical Specialties

To be eligible, the specialty society or societies in the section initially must have 50% of their physicians as members of OSMA; at the end of its third year of representation, its percentage of OSMA membership must equal the percentage of the total physician population in Ohio who are members of OSMA, calculated as of January 31, each year. If for three consecutive years thereafter this percentage is not maintained, then delegate status is terminated.

By official action, **the House adopted Resolution No. 01-87.**

By official action, the House ruled Resolution No. 02-87 and Resolution No. 03-87 were out of order, since Resolution No. 01-87 was already adopted.

RESOLUTION NO. 04-87
Spouse Active Membership

By official action, **the House voted to reject Resolution No. 04-87.**

RESOLUTION NO. 05-87
Multi-County Membership

RESOLVED, That the OSMA Council recommend that the association amend its bylaws to create a category of "multi-county members" to allow for full dues paying members of two or more societies to be active participants in each of those county medical societies; and, be it further

RESOLVED, That the OSMA Constitution and Bylaws be amended as follows:

CONSTITUTION

Article II, Section 3. Insufficient numbers of physicians for formation of component county society. If there should be an insufficient number of physicians in any county to form themselves into a component county society, such physicians may become members of the component society of an adjoining county, if they are otherwise eligible under the Constitution and Bylaws of such adjoining component society.

ARTICLE III — COMPOSITION OF THE ASSOCIATION

Section 1. Classes of Members. The Association shall consist of the following classes of members:

1. Active Members (including retired active members)
2. Multi-County Members
3. Associate Members
4. Members in Training
5. Non-resident Members
6. Honorary Members
7. Military Members
8. Affiliate Members
9. Student Members
10. Corporate Members

ARTICLE IV — HOUSE OF DELEGATES

FIRST PARAGRAPH — NO CHANGE

SECOND PARAGRAPH SHOULD READ AS FOLLOWS:

For purposes of representation in the House of Delegates, multi-county members shall be counted as members from their primary county of membership; student members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the student members of each medical school elect their own delegate; the Hospital Medical Staff Section shall have one representative to the House of Delegates commencing with the Annual Meeting in 1985, said delegate to be selected in accordance with Bylaws of the Medical Staff Section to be approved by Council; (4) delegates and alternate delegates to the American Medical Association from Ohio, Past Presidents and Past Councilors of this Association each of whom shall be an ex-officio member without right to vote unless such delegate, alternate delegate or past president be a duly elected delegate from a component society or a duly elected officer of this Association.

BYLAWS

CHAPTER 1

MEMBERSHIP

Section 1. — no change

Section 2. Classification of Membership

(b) Multi-county members. Multi-county members of this association shall comprise all those members in good standing who are members of two or more adjacent component societies. A multi-county member shall declare primary membership in one component society. Multi-county members in good standing of this

association shall have the right to vote and hold office, except that such member shall be eligible for election as Councilor, delegate or alternate delegate to the House of Delegates only from that component society designated as the society of primary membership.

CHAPTER 4
THE HOUSE OF DELEGATES

Section 2. Ratio of Representation. Each component society shall be entitled to one delegate in the House of Delegates for each one hundred (100) Active Members, Associate Members, and Members in Training, or fraction thereof, in good standing in this Association; provided, however, that only the component society in which a physician holds primary membership shall list a multi-county member on the membership roster; provided, further, that each component society shall be entitled to at least one delegate and one alternate delegate.

The names of such delegates and alternate delegates shall be submitted to the headquarters of this Association at least thirty (30) days prior to the first day of the meeting of the House of Delegates.

CHAPTER 11
MEMBERSHIP IN COMPONENT SOCIETIES

Section 1. Qualifications for membership in a component society. To be eligible for active membership, multi-county membership, associate membership or in-training membership in a component society, or other probationary or provisional type of membership of limited duration, a person must possess all of the following qualifications:

(a) He must meet all those requirements for membership in this Association which are enumerated in Section 3 of Chapter 1, hereof, and at the time of making application to the component society shall tender the appropriate Ohio State Medical Association dues and assessments for the current year. Multi-county members shall tender Ohio State Medical Association dues through the component society of primary membership; for all other component society memberships, multi-county members shall tender the dues owed to that society for local membership for the current year;

(b) He must be a bona fide resident of, or must conduct a portion of his practice in, the county in which such component society is located. Provided, however, that where a multi-county member wishes to change the component society designated as the society of primary membership, he may do so, but such change will not be effective until the new calendar year.

As used in this Section 1, "active membership" in a component society means any type of membership having voting and office-holding rights and privileges.

Subject to the provisions of the foregoing paragraphs of this Section 1, each component society shall be the sole judge of the qualifications necessary for any and all classes of membership in such society.

Section 2. Roster of Members. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by Council. Multi-county society members shall be designated separately, with the component society of primary membership clearly identified.

By official action, **the House rejected Resolution 05-87.**

AMENDED RESOLUTION NO. 06-87
Study of Alternative Structures

RESOLVED, That the Council of the Ohio State Medical Association be instructed to investigate all organizational structures which might make it more effective in assisting its members, and report its conclusions to the 1988 meeting of the House of Delegates.

By official action, **the House voted to adopt Amended Resolution No. 06-87.**

SUBSTITUTE RESOLUTION NO. 07-87
Physician Inclusion in Medicare DRG Program

RESOLVED, That the OSMA continue its opposition to the discriminatory proposal by the U.S. Office of Management and Budget to include compensation of Radiologists, Anesthesiologists and Pathologists under in-hospital DRGs; and, be it further

RESOLVED, That the OSMA continue its support of the American Medical Association and the involved specialties which initiated concurrent Resolution H. 30 and S. 15; and, be it further

RESOLVED, That the OSMA encourage members of the Congress of the United States to support these concurrent Resolutions; and be it further

RESOLVED, That a copy of this Resolution be forwarded to the AMA for information and support.

By official action, **the House adopted Substitute Resolution No. 07-87.**

AMENDED RESOLUTION NO. 10-87
Second Opinion Plans

RESOLVED, That OSMA continue to support voluntary patient or physician generated second surgical opinion programs; and be it further

RESOLVED, That the Ohio

State Medical Association is opposed to mandatory second surgical opinion plans and recommends that they be phased out of third party health care contracts.

By official action, **the House adopted Amended Resolution No. 10-87.**

RESOLUTION NO. 11-87
~~Rationing~~ Patient Care Concerns

RESOLVED, That the Ohio State Medical Association develop informational materials to explain to the citizens of this state the issues which would lead to rationing of health care; and, be it further

RESOLVED, That the Ohio State Medical Association encourage the American Medical Association through its public awareness campaign to give high priority to initiating a national discussion ~~on rationing of health care services in this nation~~. TO INFORM THE PUBLIC OF THE ADVERSE EFFECT THAT RATIONING WOULD HAVE ON THE PEOPLE OF THE UNITED STATES.

By official action, **the House voted to amend Resolution No. 11-87, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

AMENDED RESOLUTION NO. 12-87
Standardized Insurance Forms

RESOLVED, That the Ohio State Medical Association work with the various FEDERAL, STATE, LOCAL AND COMMERCIAL third party carriers to establish a uniform reporting system for forms and codes for medical care in Ohio; and, be it further

RESOLVED, That all forms approved in Ohio be in compliance with the standard AMA claim form; AND, BE IT FURTHER

RESOLVED, THAT THE RESOLUTION BE SENT TO THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES.

By official action, **the House voted to amend Resolution No. 12-87, as indicated in capital letters, and to adopt it as amended.**

AMENDED RESOLUTION NO. 14-87
Opposition to Government Legislated Physician Fee Controls and Services Under Medicare

RESOLVED, That the Ohio State Medical Association go on record to support the current American Medical Association lawsuit challenging the constitutionality of certain OBRA provisions; and, be it further

RESOLVED, That, using the example of the medical profession's experience at the hands of national legislative efforts to administer the Medicare program, that OSMA direct an educational effort to the general public, informing of the serious consequences which may occur.

By official action, **the House voted to adopt Amended Resolution No. 14-87.**

RESOLUTION NO. 17-87
Ohio State Medical Association Statewide PPO

RESOLVED, That the Ohio State Medical Association make every effort to investigate and, if feasible, develop a statewide PPO.

By offical action, **the House referred Resolution No. 17-87 to the OSMA Council.**

RESOLUTION NO. 20-87
Curtail "Fair Fee Support" Language

RESOLVED, That the Ohio State Medical Association vigorously state its opposition to the practice of indiscriminate use of "Fair Fee Support" language directed to any payor's non-participating physicians; and, be it further

RESOLVED, That the OSMA solicit from the membership and conduct a study of the available documentation which could be used in support of a campaign directed in opposition to this practice; and, be it further

RESOLVED, That, should findings of the above study warrant such action, the Council of the OSMA be authorized to select the method or methods by which to challenge the legal right of any and all third party payors to express such "Fair Fee Support" language to their subscribers whose medical services were provided by non-contracted physicians.

By official action, **the House referred Resolution No. 20-87 to the OSMA Council.**

RESOLUTION NO. 13-87
CON Legislation

The House voted that Resolution No. 13-87 be taken off the Consent Calendar, discussed it, then rejected the resolution.

RESOLUTION NO. 15-87
Assignment of Health Insurance Benefits

RESOLVED, That the Ohio State Medical Association seek to persuade health insurance carriers to honor a valid assignment of benefits to a physician who has a legitimate financial interest in a claim and to either pay the physician directly or list the physician as a co-payee on the check or draft; and, be it further

RESOLVED, That if efforts at persuasion fail, the Ohio State Medical Association initiate appropriate action through regulatory or legislative agencies or consider other means to compel third party carriers to honor a valid assignment of benefits.

The House voted that Resolution No. 15-87 be taken off the Consent Calendar, then adopted it.

RESOLUTION NO. 16-87
Catastrophic Health Insurance

The House voted that Resolution No. 16-87 be taken off the Consent Calendar, replaced it with a substitute resolution, and referred Substitute Resolution No. 16-87 to the OSMA Council.

The Substitute Resolution reads as follows:

WHEREAS, The present administration is opting for, encouraging and helping to facilitate the concept of privatization rather than government expansion thereby lending more vigor to a healthier free enterprise system; and

WHEREAS, The Federal Catastrophic Health Insurance proposal by Director of Health and Human Services, Otis Bowen, MD:

1. Is not in keeping with the Administration's Privatization concept.

2. Is not in keeping with Section 1801 and 1802 of Medicare Public Law 89-97; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association strongly urge the present Administration to address the private insurance industry, local communities, charitable organizations, local governments, and families to develop alternative private plans for Catastrophic Insurance in keeping with the concept of privatization promoted by the Administration.

RESOLUTION NO. 18-87
Enrollment as Providers in Third Party Payment Plans

By consent, **the House rejected Resolution No. 18-87.**

RESOLUTION NO. 19-87
Restore Private Ethical Medical Practice

By consent, **the House rejected Resolution No. 19-87.**

THE REPORT OF RESOLUTIONS COMMITTEE NO. 1, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Dr. Albers yielded the chair to Dr. Irons, who called for the report of Resolutions Committee No. 2.

Report of Resolutions Committee No. 2

Dr. William Dorner, Jr., Summit County, as Chairman, presented the report of Resolutions Committee No. 2:

Reference Committee 2 gave careful consideration to the several items referred to it.

RESOLUTION NO. 21-87
Annual Meeting

RESOLVED, That the Annual House of Delegates Meeting always be held in Columbus beginning as soon as possible; and, be it further

RESOLVED, That the Annual Scientific Meeting which is now held separately from the House of Delegates meeting be held in other cities approved by Council.

By official action, **the House referred Resolution No. 21-87 to the OSMA Council.**

RESOLUTION NO. 25-87
Women in Medicine Committees

By official action, **the House voted against referral and rejected Resolution No. 25-87.**

AMENDED RESOLUTION NO. 26-87
Medical Staff By-Laws

RESOLVED, That the Ohio State Medical Association create model medical staff bylaws and/or specific guidelines for use by hospital medical staffs AND THEIR LEGAL COUNSEL in Ohio.

By official action, **the House voted to amend Amended Resolution No. 26-87 as indicated in capital letters and adopted it as amended.**

RESOLUTION NO. 27-87
Risk Pooling

RESOLVED, That the Ohio State Medical Association seek the introduction and passage of legislation to establish a state health insurance risk pool to benefit those individuals who are unable to obtain health insurance coverage because of medical considerations or who do not have access to health insurance coverage; and, be it further

RESOLVED, That said legislation to establish a risk pool require the participation of all health insurance carriers doing business in the State of Ohio and that a method be developed which will in some way include funded self-insurance plans as participants in the state health insurance pool.

By official action, **the House voted to refer Resolution No. 27-87 to the OSMA Council.**

RESOLUTION NO. 28-87
The Hospital Medical Staff Independent Practice Corporation Concept (IPCC)

RESOLVED, That the Ohio State Medical Association recommend to its members consideration of the hospital medical staff Independent Practice Corporation Concept (IPCC) as a possible vehicle to be utilized by individual physicians to appropriately gain access to capitated health care delivery systems; and, be it further

RESOLVED, That the concept of the hospital medical staff Independent Practice Corporation as a possible vehicle for access of individual physicians to capitated systems of health care delivery be presented to the American Medical Association House of Delegates for its consideration.

By official action, **the House voted to refer Resolution No. 28-87 to the OSMA Council.**

RESOLUTION NO. 29-87
Peer Review of the Performance of Hospital Medical Staff Physicians

RESOLVED, That the Ohio State Medical Association evaluate the feasibility of introducing legislation similar to the American Medical Association's model state legislation which provides that medical societies would review and make recommendations to the Ohio State Medical Board on any physician conduct which may provide grounds for disciplinary action by the State Board, and that the medical society may institute such review both when requested by the State Board or when requested by other sources such as the hospital medical staff, and that the Ohio State Medical Association seek implementation of such legislation in the State of Ohio; and, be it further

RESOLVED, That the state and local medical societies of Ohio establish procedures and committees for monitoring, upon the request of the medical staff, the effectiveness of hospital medical staff peer review.

By official action, **the House voted to refer Resolution No. 29-87 to the OSMA Council.**

RESOLUTION NO. 31-87
Fee Review by the Ohio State Medical Board

RESOLVED, That the Ohio State Medical Association work with the Ohio State Medical Board to broaden the statutes of Ohio under Section 4731.22 (B) to include a separate provision concerning excessive fees as determined by a peer review committee of the state or a county medical society as grounds for disciplinary action by the Ohio State Medical Board; utilizing legislation patterned after the American Medical Association model state legislation to amend state licensure and disciplinary laws regarding excessive fees.

By official action, **the House voted to refer Resolution No. 31-87 to the OSMA Council.**

SUBSTITUTE RESOLUTION NO. 33-87
HB 150 Constitutional Malpractice (Replacing 33-87, 37-87 and 39-87)

RESOLVED, That the Ohio State Medical Association continue to actively oppose HB 150 and any other legislation that would propose mandatory Medicare assignment as a requirement for licensure; and, be it further

RESOLVED, That the House of Delegates of the Ohio State Medical Association recommend to the OSMA Council that should HB 150, or similar legislation, be enacted that the OSMA take immediate court action to nullify the law; and, be it further

RESOLVED, That OSMA would seek assistance from appropriate interest groups to assist with the court action.

By official action, **the House voted to adopt Substitute Resolution No. 33-87.**

RESOLUTION NO. 34-87
Patient Compensation Fund

RESOLVED, That to protect all Ohio State Medical Association members, the OSMA by action of the House of Delegates, strongly oppose any PCF bill.

By official action, **the House voted to refer Resolution No. 34-87 to the OSMA Council.**

RESOLUTION NO. 22-87
Swift Communication

The House voted that Resolution No. 22-87 be taken off the Consent Calendar, discussed it, then rejected the resolution.

RESOLUTION NO. 23-87
OMPAC

RESOLVED, That the Ohio State Medical Association encourage Ohio Medical Political Action Committee (OMPAC) to involve representatives of hospital medical staffs on the OMPAC local key man committees.

By consent, **the House adopted Resolution No. 23-87.**

RESOLUTION NO. 24-87
AMA Representation

By consent, **the House rejected Resolution No. 24-87.**

RESOLUTION NO. 30-87
Establishment of a Special Task Force for Foreign Medical Graduates

The House voted that Resolution No. 30-87 be taken off of the Consent Calendar, discussed it further, then rejected it.

RESOLUTION NO. 32-87
Opposition to Usage of SI Nomenclature

RESOLVED, That the Ohio State Medical Association adopt as official policy its opposition to ~~all efforts to adopt SI units as a standard nomenclature and support retention of the mass based unit nomenclature~~ MANDATED ADOPTION OF SI UNITS AND ACCEPT A GRADUAL TRANSITION TO SI UNITS.

RESOLVED, That this be forwarded to the House of Delegates of the American Medical Association for its consideration.

The House voted that Resolution No. 32-87 be taken off the Consent Calendar, amended it as indicated in capital letters with deletions as noted, and referred Amended Resolution No. 32-87 to the OSMA Council.

RESOLUTION NO. 36-87
Clinical Laboratory Certification

The House voted that Resolution No. 36-87 be taken off the Consent Calendar, replaced it with a substitute resolution, and then referred Substitute Resolution No. 36-87 to the OSMA Council.

RESOLVED, That the Ohio State Medical Association House of Delegates instruct Council of OSMA to review the subject of quality control in doctors' office laboratories performing clinical chemistry in the State of Ohio and report back at a later date.

RESOLUTION NO. 38-87
Triage of Accident and Trauma Victims

By consent, **the House rejected Resolution No. 38-87.**

REPORT A — 1987
OSMA Ad Hoc Committee to Review OSMA House of Delegates Policy

POLICIES TO BE RETAINED — 1983 OSMA HOUSE OF DELEGATES PROCEEDINGS

6-83 Workmen's Compensation Disability Determinations
17-83 Control of Look-Alike Drugs and Over-the-Counter Drug Abuse
18-83 Prescription Abuse
20-83 Handicapped Children
21-83 Problems of the Senior Citizens
30-83 Therapeutic Substitution
31-83 Drug Availability
32-83 Support of Ohio Medical Education and Research Foundation
38-83 Contraceptive Devices for Minors
39-83 Corporal Punishment in Schools
41-83 Boxing as a Health Hazard
42-83 Ohio State Medical Board
43-83 Sexual Harassment

By consent, **the House adopted Report A — 1987.**

THE REPORT OF RESOLUTIONS COMMITTEE NO. 2, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Dr. Irons yielded the chair to Dr. Albers who called up the report of Resolutions Committee No. 3.

Report of Resolutions Committee No. 3

Dr. Daniel E. Santos, Hamilton County, as Chairman, presented the report of Resolutions Committee No. 3:

Reference Committee 3 gave careful consideration to the several items referred to it.

AMENDED RESOLUTION NO. 40-87
AIDS Campaign

RESOLVED, That the Ohio State Medical Association support proclamation of AIDS as a national medical concern, support the establishment of multiple testing centers, encourage voluntary testing in all high risk groups, support programs for case reporting and contact tracing and notification, while requiring the strictest confidentiality; and, be it further

RESOLVED, That the Ohio State Medical Association lobby for Federal, State and local governments to allocate funds for AIDS education programs in schools, colleges and news media in order to help stem the tide of this deadly disease; and, be it further

RESOLVED, That this resolution be forwarded to the American Medical Association for consideration by the House of Delegates.

By official action, **the House adopted Amended Resolution No. 40-87.**

RESOLUTION NO. 41-87
Health Education on AIDS in Public School

By official action, **the House rejected Resolution No. 41-87.**

RESOLUTION NO. 42-87
Community Liaison Regarding AIDS

RESOLVED:

1. That all Ohio State Medical Association County Medical Societies be encouraged to establish an AIDS information section and resource person or committee.

2. That such resource person or committee become familiar with and if possible establish liaison with any local groups, agencies or task forces active in AIDS education or prevention.

3. That such resource person or committee establish working liaison with the Ohio State Medical Task Force on AIDS for the purpose of sharing information and coordinating activities.

By official action, **the House adopted Resolution 42-87.**

RESOLUTION NO. 43-87
Alcohol Treatment

RESOLVED, That the Ohio State Medical Association endorse legislation for an added state tax on the sale of all packaged alcoholic beverages, to help cover the cost of alcohol treatment programs.

By official action, **the House adopted Resolution No. 43-87.**

RESOLUTION NO. 44-87
Reaffirmation of Resolution No. 58-84:
Public Purchase and Consumption of Alcoholic Beverages

RESOLVED, That Resolution No. 58-84 be reaffirmed and that the Ohio State Medical Association vigorously pursue legislation raising the legal drinking age in Ohio to 21 years.

By official action, **the House adopted Amended Resolution No. 44-87.**

RESOLUTION NO. 45-87
Mail Order Prescriptions

RESOLVED, That:

1. The Ohio State Medical Association use its influence to be certain that all out-of-state suppliers of drugs for Ohio residents be licensed to dispense drugs under the laws of the State of Ohio.

2. That each supplier of bulk prescriptions, bulk being defined as any prescription that exceeds one month's supply not to include refills, be required to furnish both the patient and the prescribing physician with an exact record of the product used to fill the prescription, the manufacturer of that product, the appearance and identification codes of the product as well as a copy of the label used on the prescription package, to include directions.

3. That in cooperation with the Ohio State Pharmaceutical Association, data be obtained on the exact costs of bulk prescribing versus routine drug supply and this information be made available to county medical societies.

By official action, **the House referred Resolution No. 45-87 to the OSMA Council.**

AMENDED RESOLUTION NO. 46-87
Office Dispensing of Prescription Drugs

RESOLVED, That the Ohio State Medical Association develop guidelines, based on legal and ethical considerations, for physicians who choose to dispense drugs in their offices; and, be it further

RESOLVED, That these guidelines be published for the benefit of all physicians in Ohio.

By official action, **the House adopted Amended Resolution No. 46-87.**

RESOLUTION NO. 47-87
Third Party Interference with Physician Prescribing Patterns

RESOLVED, That the Ohio State Medical Association will solicit the cooperation of the Ohio State Pharmaceutical Association to address this issue with insurance companies in an effort to provide appropriate medical guidelines to be considered in the promotion of such mail prescription benefit plans.

By official action, **the House referred Resolution No. 47-87 to the OSMA Council.**

SUBSTITUTE RESOLUTION NO. 48-87
Labeling of Generic Substitutions

RESOLVED, That the OSMA reaffirm the position in Resolution No. 60-80 which calls for the OSMA to insist through the legislature or the Ohio State Board of Pharmacy to ensure that if a generic medication is given, that it be labeled as such and not mislabeled with a brand name; and that OSMA strongly encourage compliance with the Ohio Revised Code.

By official action, **the House adopted Substitute Resolution No. 48-87.**

RESOLUTION NO. 49-87
Parking for Temporarily Handicapped

RESOLVED, That the Ohio State Medical Association support legislative efforts to accelerate the issuance of handicapped parking permits to those patients who are temporarily handicapped.

By official action, **the House adopted Resolution No. 49-87.**

RESOLUTION NO. 50-87
Bedside Blood Glucose Monitoring in Hospitalized Diabetic Patients

By official action, **the House rejected Resolution No. 50-87.**

AMENDED RESOLUTION NO. 51-87
Statewide Ethics Committee

RESOLVED, That the Ohio State Medical Association, through its Judicial and Professional Relations Committee, develop a statewide ethics committee to serve as a resource for its physician members; and, be it further

RESOLVED, That the proposed ethics committee be composed of OSMA members, but avail itself of a broad case of resource people, including but not limited to lawyers, clergy, hospital representatives, ethicists and consumers.

By official action, **the House adopted Amended Resolution No. 51-87.**

RESOLUTION NO. 53-87
Civil Aeromedical Helicopter Industry Safety

RESOLVED, That the Ohio State Medical Association determine through careful study and research:

1) the identity of all civil aeromedical helicopter programs in the State of Ohio along with their accident rates,
2) the factor(s) necessitating the implementation of each program, as well as the reasons for continued existence from each program administrator; the number of pilots participating in each program; program funding; the number of aeromedical helicopter programs per city; and any other factors deemed necessary in presenting an objective picture of the status of the aeromedical helicopter industry in the State of Ohio; and, be it further

RESOLVED, The OSMA publish these results for the aeromedical helicopter industry in Ohio in *OHIO Medicine* along with any other safety recommendations not contained in the report of the safety committee of the American Society of Hospital Based Emergency Aeromedical Services, by December 1, 1987.

By official action, **the House referred Resolution No. 53-87 to the OSMA Council.**

RESOLUTION NO. 54-87
Continual Medical and Patient Education
Socio-Political Economic Topics

RESOLVED, That the House of Delegates of the Ohio State Medical Association ask OSMA Council to explore possible negotiations with OMEN Directors

to arrange to have a broadcast perhaps once every six to eight weeks by a panel of experts on current developments in the Socio-Political-Economic arena as related to physicians and patients.

By official action, **the House referred Resolution No. 54-87 to the OMSA Council.**

RESOLUTION NO. 55-87
Early Detection

RESOLVED, That the Ohio State Medical Association encourage providers, employers and third party carriers to develop mechanisms for funding programs for early detection of life threatening diseases under physician direction, with adequate follow-up, as procedures important in saving lives and health care dollars.

By official action, **the House adopted Amended Resolution No. 55-87.**

SUBSTITUTE RESOLUTION NO. 35-87
OMSA Policy on Advertising (Replacing 35-87 and 56-87)

RESOLVED, That the Ohio State Medical Association recognize the increasing use of public relations/service announcements which purport to enhance the public's ability to make informed decisions regarding health care; and, be it further

RESOLVED, That the OSMA encourage its members who wish to market their services to adopt marketing practices:

1. which are not false, fraudulent, deceptive or misleading; and

2. which are designed to give the public adequate information regarding the nature and scope of the various medical specialties to permit individuals to make informed choices regarding their selection of physicians; and, be it further

RESOLVED, That the Ohio State Medical Association examine the issue of hospital advertising.

By official action, the House adopted Substitute Resolution No. 35-87.

RESOLUTION NO. 57-87
Student-to-Student Community Health Education Project

RESOLVED, That the Ohio State Medical Association support the concept of the Student-to-Student Health Education Project at all Ohio medical schools and provide financial support for printing and mailing costs of brochures and project handbooks for this OSMA-MSS project.

By official action, **the House adopted Amended Resolution No. 57-87.**

RESOLUTION NO. 52-87
Reaffirmation of Resolution 46-84: Mandatory Use of Protective Helmets for Motorcyclists

RESOLVED, That Resolution No. 46-84 be reaffirmed — that the Ohio State Medical Association make every effort to obtain enforceable legislation that mandates the use of protective headgear for all motorcycle operators and passengers in Ohio.

By consent, **the House adopted Resolution No. 52-87**

RESOLUTION NO. 58-87
Smoke-Free Environment

RESOLVED, That Ohio State Medical Association work with the Ohio Hospital Association to effect a smoke-free environment in all Ohio hospitals.

By consent, **the House adopted Resolution No. 58-87.**

PRESIDENT'S ADDRESS

Dr. Alber's speech opened with a stimulating audiovisual presentation which highlighted the past year's major accomplishments of the OSMA, as well as emphasizing challenges for the future. The show cited that even though OSMA is diverse in membership, the organization must speak together as one to protect the rights of physicians and their patients — with quality as its first commitment.

The slide show included the legislative scene, in which approximately 200 bills introduced each year impact health care. It emphasized that it isn't enough just to react to legislative issues. The OSMA works to initiate change when a vital medical issue needs to be addressed. A vivid example is the tort reform legislation currently in the Ohio General Assembly.

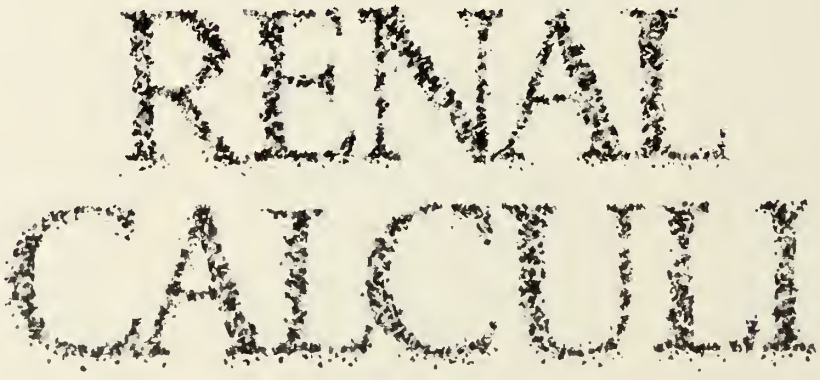
The show, which was prepared at the request of Dr. Albers, also described the important work being done with state agency rules, the cooperative effort with many agencies and organizations which impact health care, the OSMA ombudsman's ongoing efforts to untangle red tape in the arena of reimbursement, and the contract analysis program currently being initiated.

Communications, both internal and external, were given high priority in the show. In addition to educating physicians about the changing environment of health care, the OSMA must also provide vital information to patients and work in close cooperation with the news media. Internally, OSMA has redoubled its efforts to establish a strong link between the OSMA and component medical societies, as well as between OSMA and the many medical specialty societies.

Innovation is the key word in communications. The OSMA has installed a toll-free hotline (1-800-346-OSMA) which gives members access to association activities. However, communication is a two-way street and successful medical policy can only be formulated by the thoughtful give-and-take of ideas.

Following the slide show presentation, Dr. Albers turned his attention to the future and the

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The Lithotripter uses shock waves to bombard kidney stones into sand-like particles inside the body. The residue is then easily passed. Although the theory behind Lithotripsy is simple, the process is precise. The stone is pinpointed inside the body with fluoroscopy and shock wave firing is synchronized with the patient's heartbeat by electrocardiogram. Usually, the entire process takes about an hour.

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For your brochures or other information about Lithotripsy and our kidney stone treatment program, call CAMC: in West Virginia at 1-800-654-0159; from out of state, call 304-340-7315.

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difficult financial, social and ethical issues which face the medical community. The growing population of elderly in the United States, rising health care bills and tighter government controls in the health care arena may lead to rationing and a multi-tiered system of care, Dr. Albers warned.

Other ethical issues physicians face include genetic engineering, right-to-life, surrogate motherhood and in vitro fertilization. Organized medicine needs to set ethical guidelines in these areas, according to Dr. Albers and to demonstrate to the public that physicians are concerned about the welfare of their patients.

In order to remain effective and united in the future, the OSMA must represent the interests of all of its physician members — be they in private practice, HMO or IPA situations. "An organization is no stronger than its membership," he said, and those elements which threaten to divide physicians must be overcome.

Finally, Dr. Albers expressed concern over the fact that fewer and fewer young people are choosing to go into medicine today. He stated that some important questions need to be asked if this situation is to be remedied. These questions concern the length, content and expense of medical education, along with the current trend towards overspecialization and the changing image of the physician in society today.

The OSMA's efforts to recruit young physicians, women physicians, medical students and residents into its ranks will help to ensure that organized medicine remains viable in the years ahead, he concluded.

The House accepted the report by acclamation and it was filed.

THE REPORT OF RESOLUTIONS COMMITTEE NO. 3, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Inaugural Ceremony

Ted Ball, MD, escorted Mrs. Irons and the Irons' children to the rostrum.

Dr. Abromowitz administered the Presidential Oath of Office to Dr. Irons. Dr. Irons introduced the members of his family to the House. He also introduced friends and associates seated in the audience.

Dr. Albers then presented to Dr. Irons the official gavel and the President's Medallion. Dr. Irons briefly addressed the House.

The Irons family was given a standing ovation.

Stanley J. Lucas, MD, escorted Mrs. Albers to the rostrum.

Dr. Irons presented to Dr. Albers the Past President's pin, the President's plaque, a replica of the President's Medallion to Mrs. Albers and a replica of the President's Medallion to Dr. Albers. Dr. Abromowitz presented a personal gift to Dr. Albers.

Dr. Albers thanked the OSMA Council, the House and the OSMA Staff and his staff for their support during his year as President.

The House gave Dr. and Mrs. Albers a standing ovation.

Dr. Albers introduced Carl E. Spragg, MD, former OSMA Councilor.

Luther W. High Resolution

Dr. Charles G. Adams, Eleventh District Councilor, asked for permission to present a resolution commending Dr. Luther W. High, long-time Delegate of Holmes County.

The resolution reads as follows:

Honorary Resolution — May, 1987

WHEREAS, Dr. Luther High has been a delegate from the Holmes County Medical Society to the Ohio State Medical Association House of Delegates for many years; and

WHEREAS, Dr. High has represented his Society with regular attendance, deep insight, and wise counsel; and

WHEREAS, Dr. High has informed the Eleventh District Delegation that this will be his last year as a Delegate from his Society; therefore be it

RESOLVED, That the House of Delegates of the OSMA extend its deep gratitude to Luther High for his many years of service to OSMA and the people we serve.

The House approved this resolution and gave Dr. High a standing ovation.

Dr. Abromowitz addressed the House expressing his thanks for the support he received during his years on Council.

There being no further business, the House of Delegates adjourned, sine die.

ATTEST: Herbert E. Gillen
Executive Director

Migraine blood deficiencies

During a classic migraine, cerebral blood flow is curtailed enough to cause ischemia and neurological deficits, according to a study in the *Archives of Neurology.*

The study, conducted by researchers at Bispebjerg Hospital in Copenhagen, suggested that neurological deficiencies which accompany migraines are vascular in nature.

The researchers measured cerebral blood flow in 11 migraine patients and found reductions averaging 52% during migraine periods. In seven of these patients, blood flow during migraine was found to be insufficient for normal cortical function.

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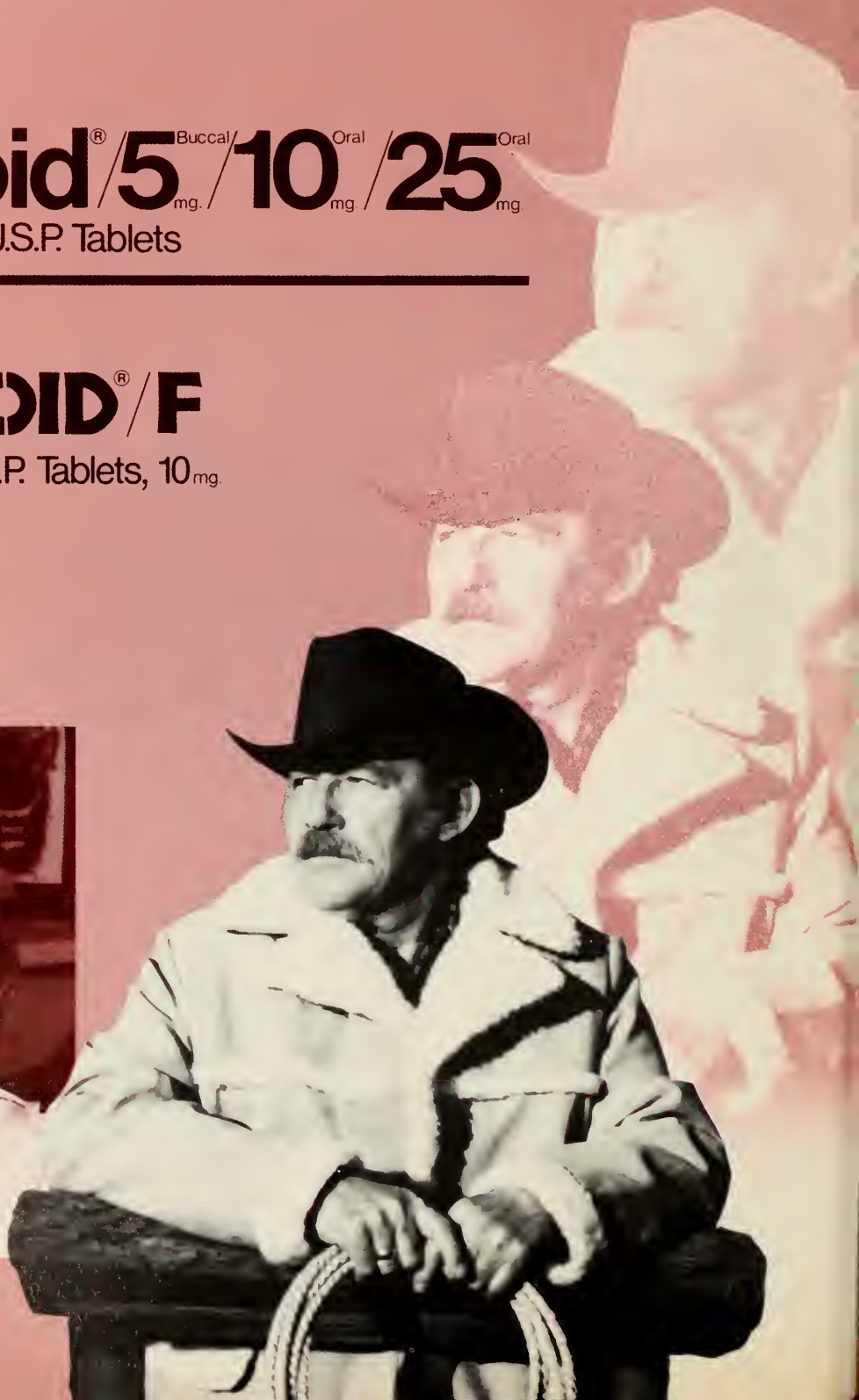
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Dimensions of Grief

By Stephen R. Shuchter, MD; Jossey-Bass Publisher, 1986; 360 pages; $24.95

The death of a spouse is one of the most traumatic events in a person's life. In the U.S., it is experienced by more than 80,000 every year. The grief and mourning that follow affect the surviving spouses profoundly, and differently. Each individual responds in his or her own unique way. Some grieve for years, becoming tearful anytime they think of their spouses. Others do not display any noticeable emotion. People have been asking for years — what is normal grief? When is grief pathological?; how long should normal grief last?; is it never-ending?; when does grief require professional intervention?; what kind of interventions are helpful? Such questions provide the impetus for this book.

The author is Stephen R. Shuchter, MD, a psychiatrist from San Diego, California, who is currently director of the University of California San Diego Gifford Mental Health Clinic, and a principal investigator of the San Diego Widowhood Project. He is also a clinical professor of psychiatry at the University of California at the San Diego School of Medicine.

This book is based on the data derived from a study by the San Diego Widowhood Project. Seventy people (21 men and 49 women) were followed prospectively starting one month after their spouses' death until five years later (from 1978 to 1983). The data include material obtained from 500 tape-recorded interviews with widows and widowers. Although the study itself which is described in the book's appendix includes statistical data, the book is unique since the entire eight chapters are characterized by the richness and breadth of personal experiences of the widows and widowers. The author makes frequent use of the quoted material, giving the writing a personal touch.

He begins with a clear description of the dimensions of grief. These include the emotional and mental responses, the coping with the emotional pain of loss, the changes affecting daily functioning in the life of bereaved, the changes in their personal relationships and the changes in one's identity. The first chapter ends by reviewing the six major tasks of grief which include the following:

1. Learning to experience, express and integrate painful affects.
2. Finding the most adaptive means of modulating painful affects.
3. Integrating the continuing relationship with the dead spouse.
4. Maintaining health and continued adaptive daily functioning.
5. Adapting successfully to altered relationships.
6. Developing an integrated healthy self-concept and stable world view.

The above six tasks of grief correspond to six dimensions of grief which are covered profoundly in the remaining six chapters.

A detailed account of the grieving individuals is also presented. They include emotional pain, shock, sense of loss, anger, guilt, regrets, anxiety, intrusive images disorganization, loss of control, apathy and loneliness.

The author gives the bereaved person's account in rich, personal language; their pains, the wrenching of their insides — like "a knife in the gut." Here are some examples: "The most difficult thing to deal with has been just knowing that he's not here after 36 years. I don't know, you still expect to see him coming in . . . At times, even when I'm with other people, there is a big empty hole in the center of my body." (p. 20). "You feel as though half of your brain has died because partners store different sorts of information." (p. 21). Approximately half of the subjects experienced guilt exemplified in statements such as: "Why was Eileen taken and I was left behind? She was so good." The book covers the various coping skills of the bereaved, such as: realization, avoidance and involvement with others. The main adaptive value of these coping skills are to reduce the pain of grief and to enable the survivor to continue living in the real world, meeting the needs of daily living.

Dr. Shuchter describes, in a helpful style, the many forms in which the bereaved continue to maintain their relationship with the lost spouse, i.e. living legacies, rituals, memories, dreams and symbolic representations. These are viewed by the author as not only as inevitable manifestations of emotional needs, but also as a necessary phase for the successful "resolution" of grief. These points are demonstrated through a myriad of rich case vignettes, each so special, unique and human. For example: "She loved the dog, was crazy about him, a beautiful Great Dane, and I took good care of him. And every now and then, I realize when I take care of him (the dog) that I am taking care of the material thing that she loved the most — that was the living thing that carried on from her. I think my relationship to the dog carries on the relationship with her." Dr. Shuchter also describes the changes in functioning found in the bereaved including the prevalence of depression,

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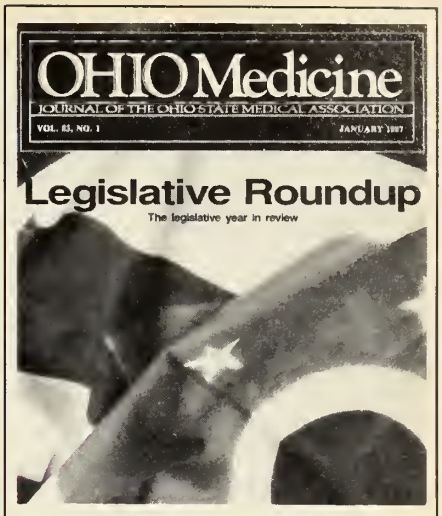
alcoholism and an increase in the risks to one's physical health. In addition, he examines issues related to job and social functioning. Chapter six covers the bereaved experience in developing new friendships, romances, dealing with their sexuality and considering remarriage. These aspects of grief are seldom discussed in other professional books about grief.

The author devotes a whole chapter to examine how the bereaved person's identity is reshaped. The changes in the survivor's identity take place on many levels including role functions, life directions, personal qualities, belief systems and esthetics.

The last chapter examines the therapeutic implications for dealing with the bereaved, and the therapeutic value that support groups and professionals role play in organizing such a group.

This book is a valuable addition to the literature on loss and grieving. It adds a unique dimension of personal experience of the bereaved individual. All professionals involved in the health and human services will find it extremely helpful to the understanding of this universal phenomenon. Moreover, bereaved people and their families too, will gain a deeper understanding of their own experiences.

— **Moshe S. Torem, MD**
Chairman, Department of Psychiatry
Akron General Medical Center
Akron

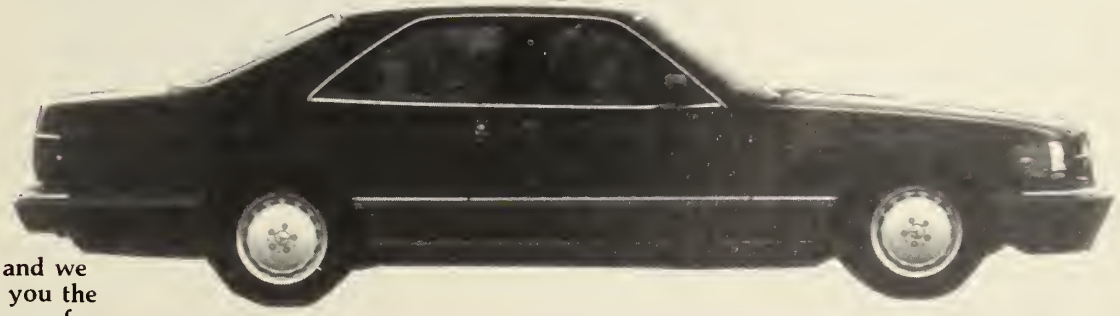


Next month in Ohio Medicine:

- **The Mid-Year Legislative Roundup**
  It has been a hectic half-year in the legislature as bills covering every medical subject from malpractice to faith healing came up for review. Next month, a report on what happened . . . and why . . . from OSMA's Legislative staff.

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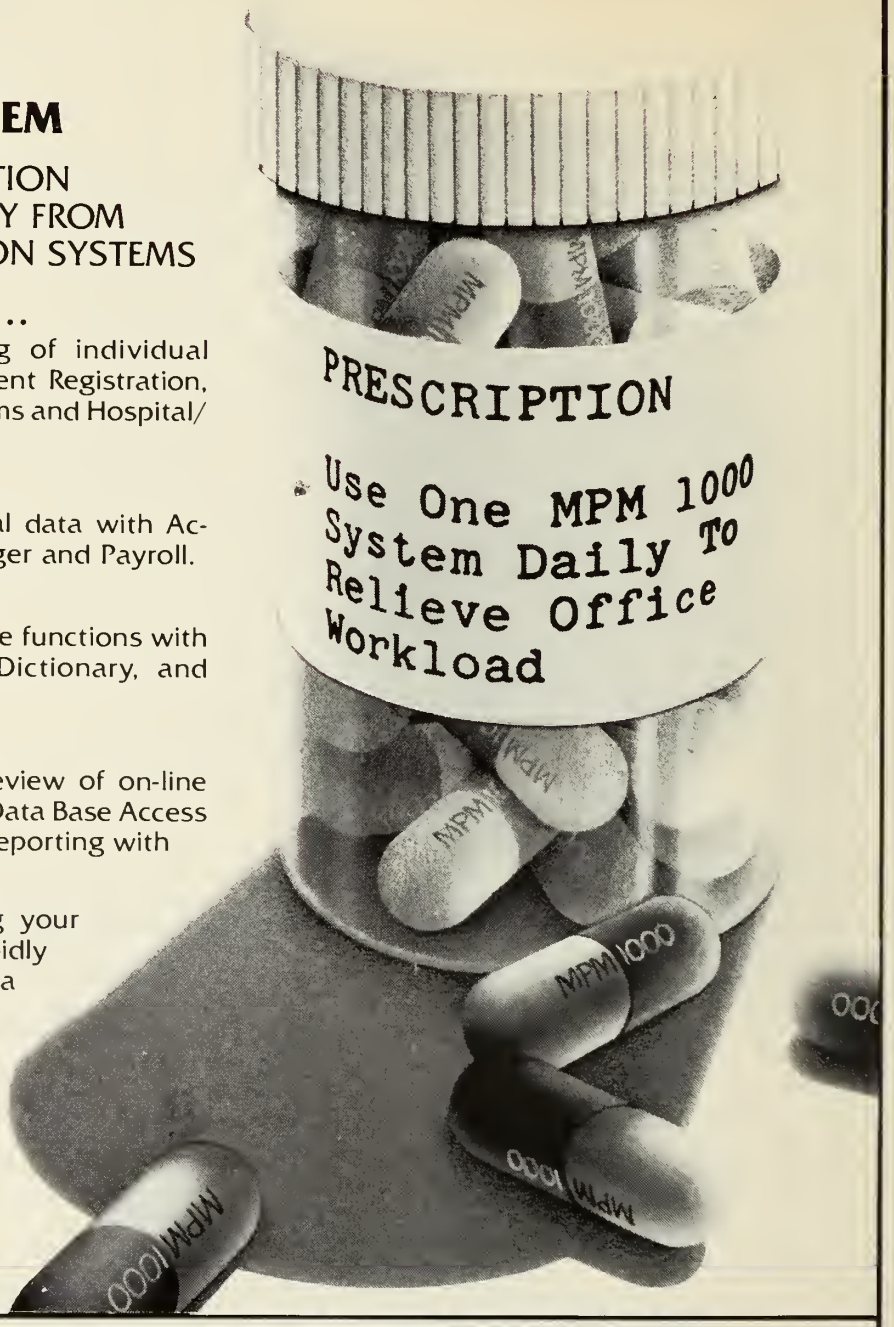
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Health and Wealth

By Lawrence Grey, JD

In the good old days, people used to enjoy being healthy. Indeed, they used to have a phrase, "He enjoys good health." You never hear that anymore because nowadays people don't enjoy good health, they work at it.

Consider health and wealth. The average American has an adequate home, a car that runs, decent clothes, and a few amenities. The average American has, all in all, a pretty good life. But would he say "I enjoy my wealth?" Of course not! He doesn't have any wealth! What he has is a job. He works at his job and they pay him money; sometimes a lot of money, but he has to work for it.

Contrast this average man or woman with the rich American. He has money without having to work for it everyday. He goes through life having what he wants without ever worrying about the cost. He is, in a word, wealthy.

Health ought to be like wealth. One ought to enjoy health, without really having to work at, or worry about it. To remain wealthy, a person must follow sound investment principles, and make an occasional visit to the broker or the bank to resolve some problem. To remain healthy, a person ought to be able to do the same, i.e. follow essential health rules, and see a doctor if a problem comes up.

But of course we can't do that anymore. Today we are inundated with health warnings. "Caffeine causes strokes." "Sugar is poison." "Salt will kill you." We all know what cholesterol is. Cholesterol is what nature puts in food to make it taste good. But the pervasive unrenitting campaign against cholesterol has lent us a nation of neurotics. Half the people are so afraid, they shun any food with any cholesterol, and as a result haven't had a decent meal in years. The other half have not changed their eating habits, but having a good meal scares them. They feel guilty or uneasy, but not enough to change their habits. The national campaign against cholesterol has given us those two classic symptoms of hysteria — avoidance and denial.

We should cut the hysteria; we should tone down the warnings. Being healthy is like being wealthy; you have to avoid excesses. Eating broccoli is like having a savings account. You should do it, but no one is really expected to enjoy it. Speculating in the stock market in options or futures is, like whipped cream, deliciously wanton and great fun.

Some people, the unhealthy and the unwealthy, should follow the advice of their medical advisor and their financial advisor, and avoid certain things like the plague. But general health advice, like general financial advice, should be directed toward a sound strategy which makes the person feel comfortable.

I once told my stock broker I'd like to play some options. He laughed, advised a very small investment, and said I'd have fun and lose money. He was right. I once told my doctor that I enjoyed a breakfast of bacon and eggs. He got a stern look on his face, mumbled something about strokes and death, and said I should not eat more than two eggs a week. So now I eat two eggs, but I don't enjoy them. Why didn't he say, "Eggs are okay. A couple won't kill you. You really ought to enjoy a couple every week, but more than that is bad for you?"

I am sick of health warnings; warnings imply disasters, like storm warnings or tornado warnings. I want health advice — advice on how to enjoy good health. Like most of us, I'm never going to enjoy wealth, but I would like, as people once did, to enjoy good health. **OSMA**

Lawrence Grey is a frequent contributor to **OHIO Medicine.** *He presently serves as Judge of the Fourth District Court of Appeals, Athens.*

OBITUARIES

GRIFFIN M. ALLEN, MD, Cleveland; Meharry Medical College, Nashville, TN 1945; age 66; died May 2, 1987; member OSMA and AMA.

FRANK M. BARRY, MD, Penney Farms, FL; Case Western Reserve University School of Medicine, 1938; age 75; died March 4, 1987; member OSMA.

EUGENE R. BENEDETTO, MD, Alliance; Creighton University School of Medicine, Omaha, NE, 1939; age 73; died April 8, 1987; member OSMA and AMA.

WILLARD A. BERNBAUM, MD, Cleveland; Case Western Reserve University School of Medicine, 1982; age 35; died May 1, 1987; member OSMA and AMA.

SYLVIA BUBIS CLAYMAN, MD, Columbus; University of Michigan Medical School, Ann Arbor, MI, 1939; age 71; died April 16, 1987; member OSMA and AMA.

HARVE M. CLODFELTER, MD, Columbus; University of Kansas School of Medicine, Lawrence-Kansas City, Kansas, 1930; age 81; died April 1, 1987; member OSMA and AMA.

ROGER P. DANIELS, MD, Pomeroy; Case Western Reserve University School of Medicine, 1933; age 82; died March 2, 1987; member OSMA and AMA.

PAUL W. EBERT, MD, Dover; Case Western Reserve University School of Medicine, 1945; age 66; died April 1, 1987; member OSMA and AMA.

WILLIAM G. ECKMAN, MD, Kettering; University of Cincinnati College of Medicine, 1944; age 67; died April 6, 1987; member OSMA and AMA.

BEATRICE FOCKLER, MD, Columbus; Ohio State University College of Medicine, 1930; age 79; died March 24, 1987; member OSMA and AMA.

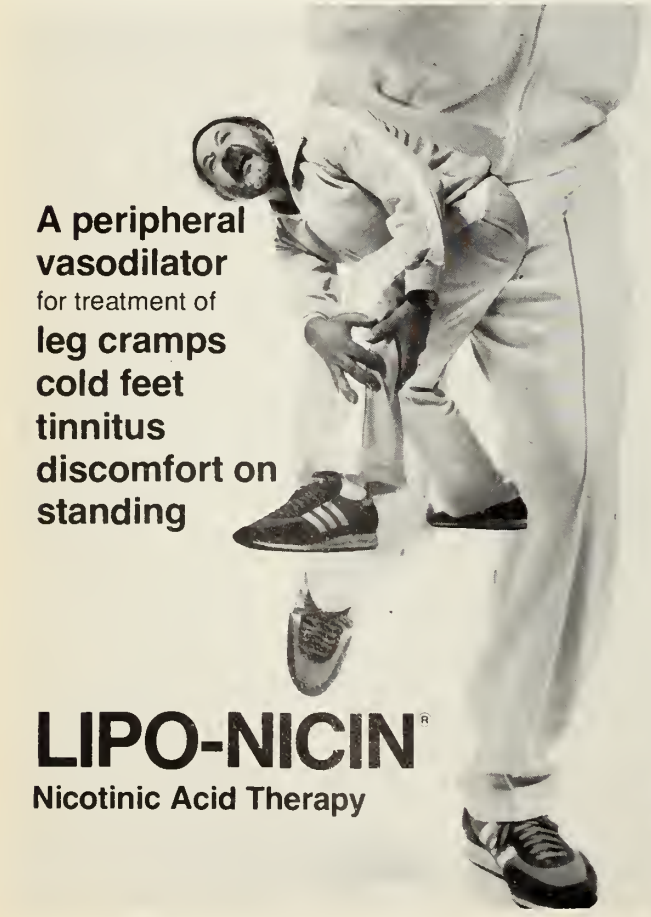
EDWARD A. GRIBBIN, MD, Toledo; St. Louis University School of Medicine, St. Louis, MO, 1927; age 87; died April 11, 1987; member OSMA and AMA.

ROBERT C. GRUBBS, MD, Columbus; Ohio State University College of Medicine, 1935; age 79; died April 27, 1987; member OSMA and AMA.

THOMAS HALE HAM, MD, Hanover, New Hampshire; Cornell University Medical College, New York, NY, 1931; age 81; died March 23, 1987; member OSMA and AMA.

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in a special base of prolonged therapeutic effect.
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AVAILABLE: Bottles of 100, 500.

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Niacinamide .....75 mg.
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Vicodin® provides greater patient acceptance

COMPARATIVE PHARMACOLOGY OF THREE ANALGESICS

	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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...and longer lasting pain relief– up to 6 hours.

- Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.[1]
- In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.[2]

Plus...

- Vicodin offers the convenience of CIII prescribing.
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hydrocodone bitartrate 5 mg. (Warning. May be habit forming) with acetaminophen 500 mg.

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CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
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Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
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PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
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Revised, April 1982. 5685

1 Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2 Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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Q. *My office provides limited clinical lab services, mainly as a convenience for my patients. I am still uncertain about how I can charge my Medicare patients for lab, since I do not participate or routinely take Medicare assignment. Am I permitted to charge my regular fee for lab, and* not *file any Medicare claim? I was informed that this procedure is legal.*
MD, Central Ohio

A. Mandated Medicare assignment is *only* required for physicians who wish to file a claim to Medicare for direct reimbursement according to a statewide fee schedule. If an assigned claim is not filed, Medicare will absolutely not reimburse any party involved, including the patient. You are permitted to bill lab services for Medicare patients at your going rate, but you may find that many elderly patients will object to paying for lab services out of their own pocket, and insist that you file their claim and accept assignment. Frankly, we do not believe this system is always good for patient relationships, and unless you are in a position to discuss this with each patient, and obtain their concurrence, it is likely that problems will occur.

Q. *Occasionally when I admit a patient, especially those enrolled in Medicare, the claim for my services as attending physician is rejected and my patient receives notice that my services are more services for this diagnosis than Medicare covers unless there were unusual circumstances, and that Medicare does not pay for like services by more than one doctor. What does this mean?*
MD, Southern Ohio

A. Reasonable and medically necessary services by more than one physician for the same patient during the same hospital confinement usually are

continued on page 564

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	You	Spouse
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Birth date	__/__/__	__/__/__
Sex	☐ M ☐ F	☐ M ☐ F
Smoked cigarettes last 12 months	☐ yes ☐ no	☐ yes ☐ no
Coverage needed by	__/__/__	__/__/__

Ombudsman . . . *continued*

reimbursable by health insurance when unrelated medical conditions exist which require diverse specialized services of more than one physician.

Most claims rejections occur because carriers cannot determine that two or more physicians were necessary for the treatment of different and unrelated diagnoses or conditions. The carriers suggest that involved physicians document on their claims that the services were "performed concurrently with Dr. _____, but for totally unrelated diagnosis."
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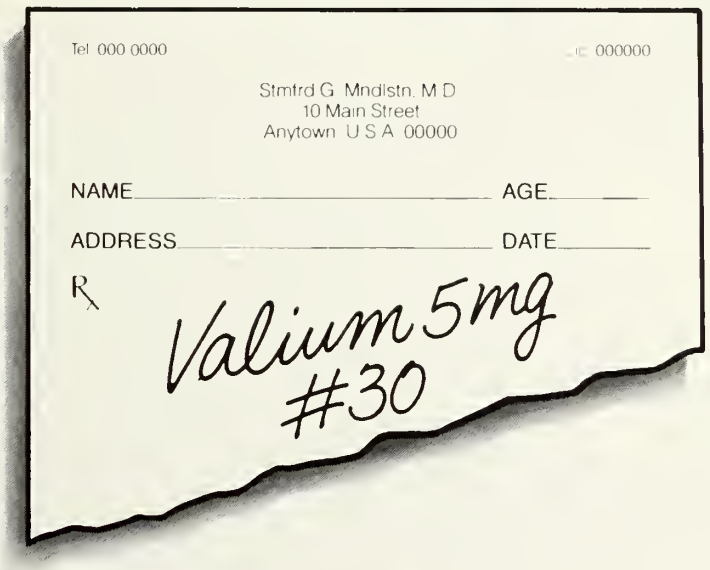
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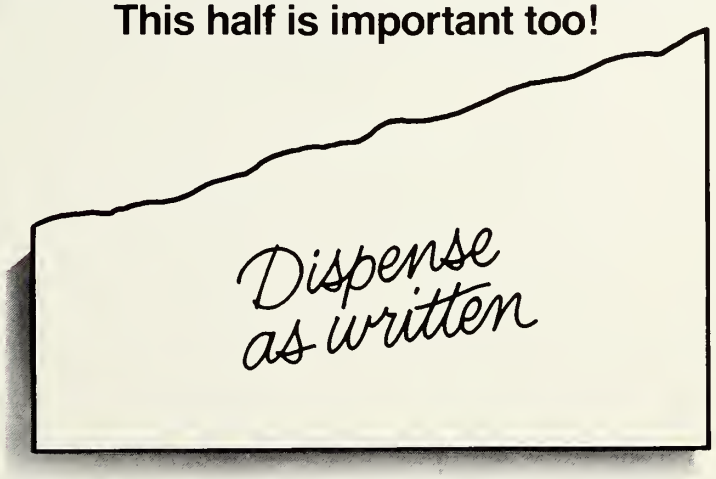
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VOL. 83, NO. 9 SEPTEMBER, 1987



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The Mid-Year Legislative Roundup

Including a full report on House Bill 327, the medical professional liability reform bill.

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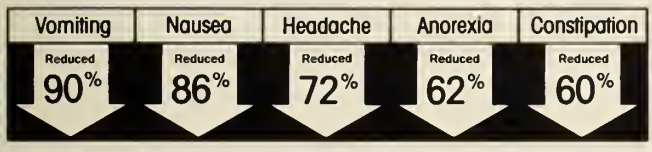
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References: 1. Feighner JP, *et al: Psychopharmacology 61*: 217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
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Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
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Published monthly under the direction of The Council for and by members of OHIO Medicine, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1987 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: OHIO Medicine, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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FROM THE EDITOR

Best Laid Plans

Last month, we had every intention of focusing this issue on the future of medical education. Story assignments were made and completed — but before we could go to press, we were suddenly inundated with material that couldn't wait for publication. Since flexibility is at least 90% of every editor's job (except where deadlines are concerned, of course), we decided to hold the future of medical education off for another month so that we could bring this timely material to you. Our apologies to those of you who have helped us with our medical education issue (and those who may have been looking for it), but we assure you that the subject *will* be given in-depth attention next month.

Meanwhile, in light of the recent developments that have occurred in malpractice legislation in the state, we are bringing you a mid-year version of the Legislative Roundup which is typically featured in our January issue. It was the contention of OSMA's Legislative staff, however, that House Bill 327, the medical professional liability reform bill, had so many followers that it would be a disservice to wait until the beginning of next year to comment on its passage. They quickly compiled a report of legislative activity to date, giving prominent attention to the liability bill — and, in turn, we made room for it by bumping our scheduled material back a month. Their report will not only be able to tell you, at a glance, how the liability bill fared through the state legislature, but it will also allow you to check the progress of any one of a number of medically-related issues now pending before the legislature.

Also in this issue, look for the list of names of those individuals who have contributed to the Professional Liability Legislative Action Fund, established this past March by Immediate Past President John E. Albers, MD. This fund, which now boasts a total of over $150,000 has been instrumental in OSMA's fight for liability reforms — and continues to be of help in such matters as patient/public/physician education, legal assistance and ongoing legislative activity. Contributions, of course, are still welcome — see the story on page 605 for details.

Also look for more organizational news in the form of the report from the American Medical Association's annual June meeting, and the minutes from the Medical Student Section's Annual Meeting.

Next month, of course, we will take that anticipated look at the future of medical education . . . from both the dean's perspective and the student's. A related article will describe what's being done to help students deal with "medical school stress," while yet another will take a probing look at the value of continuing medical education. Don't miss it!

Karen S. Edwards

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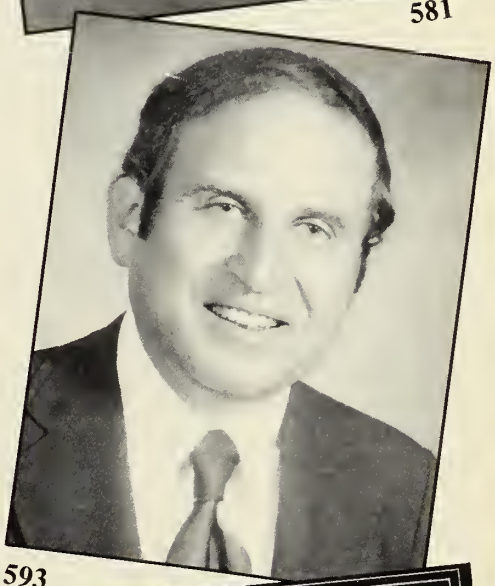
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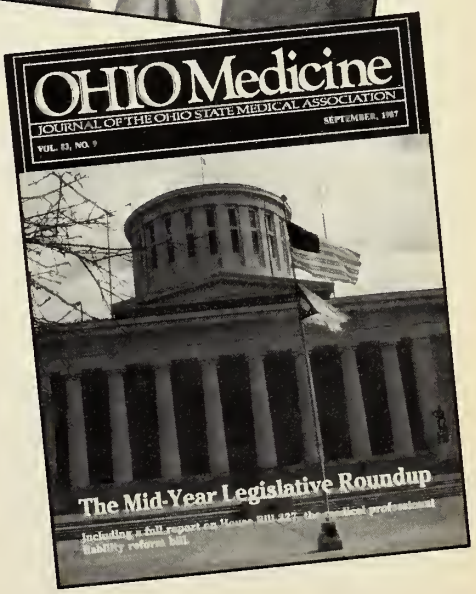
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OUR COVER

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J-6138 January 1986



A Strong Dose of Clout

As we move into the end of the '80s, the legislative process and bureaucracy seems to be more and more intertwined with the private practice of medicine. Special interest groups attempt to legislate medical treatment and procedures; allied health practitioners attempt to gain licensure through legislative schemes and bureaucrats attempt to ration health care in the name of fiscal responsibility.

Strong medicine is needed to ensure physicians' and patients' rights. A successful prescription for legislative success and perseverance should include several important ingredients — the most important being a learned, respected, dedicated and hard-working legislative staff, such as we enjoy here at the OSMA. The ever-continuing process of the legislative morass must be watched over and massaged on a daily basis — sometimes 18 to 20 hours a day. The physicians and patients of Ohio are most fortunate to have this representation.

One of the more frequently asked questions by physicians pondering membership in the association is: "What's OSMA done for me today?" To them, I resoundingly answer, "Legislation."

However, to continue to ensure our success in this arena, the above formula must include a large dose of clout. The clout in this instance is represented by the unified and total support of the profession by membership in the OSMA. This support may take several forms — financial support, for example, in the form of dues, helps support the legislative activities of the OSMA and, of course, OMPAC donations are vital. After all, meaningful and timely contributions to the legislative process is in the interest of Ohio medicine.

That the above formula works well is evidenced by the fact that House Bill 327, the medical professional liability legislation, passed with a resounding majority in both the Ohio Senate and the Ohio House of Representatives.

The passage of this bill has received much well-deserved notice and acclaim. However, let me draw your attention to a less publicized but also significant legislative event — the retention of a 4% Medicaid provider fee increase from the Ohio Department of Human Services, effective January 1, 1989. This increase is significant in view of the fact that few other budget items received any greater increase. Another onerous proposed legislation is HB 150, which ties mandated assignment to licensure. Currently, this bill remains in committee, thanks to the legislative activity of the OSMA.

Not only must we react to proposed and ongoing legislation, but we must look ahead to what type of legislation might further benefit the practice of medicine. For example, we could look to some type of legislation which would ensure fairer treatment of Ohio physicians by the PRO. In addition, legislative protection from discovery for physicians engaged in meaningful peer review is absolutely necessary if we are to fairly "police the profession."

The next time you, as a physician, become irritated with another legislative imposition and/or the intrusion in the patient-physician relationship, may I humbly suggest a strong dose of clout? The initial and most important place to start would be with your local state representatives and senators, for as important as the OSMA's clout is, you, as an individual, have much more clout in your own community. A personal contact or

continued on page 617

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LETTERS TO THE EDITOR

Other symptoms of child abuse

To the Editor:

I read with pleasure your articles on recognition of signs of child abuse in the June 1987 issue of *OHIO Medicine*. I thought the articles were well-written and factual. I did, however, feel that emphasis is required on other-than-physical findings in such cases. The child that becomes disinterested, irregular in his or her attendance at school, exhibits lack of grooming, shows failure or some other change in his or her school performance, a disinterest in friends and everyday activities should also be noted. There was a slight mention of infections, but this must also be emphasized in speaking of recognizing child abuse. The child abuse victim is more than a mere "physical-exam" candidate.

Sincerely,
Cyril V. Gross, MD
Canton

A judicial industry?

To the Editor:

In the June issue of *"OHIO Medicine"* (p. 395) there is an interesting fact that nearly half of the physicians responding to an OSMA survey on professional liability last year have already been sued for malpractice at least once.

In the same issue (p. 375) Dr. Robert J. White is asking us: "Would you want your child to become a physician?"

When combined together, the question should say: "Would you want your child to enter a profession with a nearly 50% risk of being sued at least once for malpractice?"

While I do not think of all physicians as being faultless or that all of them possess a model type of moral standards, the increase of malpractice cases against physicians is quite worrisome. Could it be that physicians, like all other citizens, are simply victimized by a constantly growing, stronger judicial industry?

Are our honorable judges and lawyers a part of an industry? Why not? Any system that generates money is an industry! And the more money one gets in this materialistic world, the more honor one receives.

I think it would be very interesting for us if *OHIO Medicine* would find the total amount of dollars paid by physicians and insurance companies to plaintiffs, courts and defense lawyers in 1986. The plaintiffs' lawyers get their usual lavish and very stimulative one-third at least.

Finally, is a physician of today, by paying an enormous amount of money for liability insurance coverage, not indirectly exploited by the judiciary industry?

Milan Radivoyevitch, MD
Cleveland Heights

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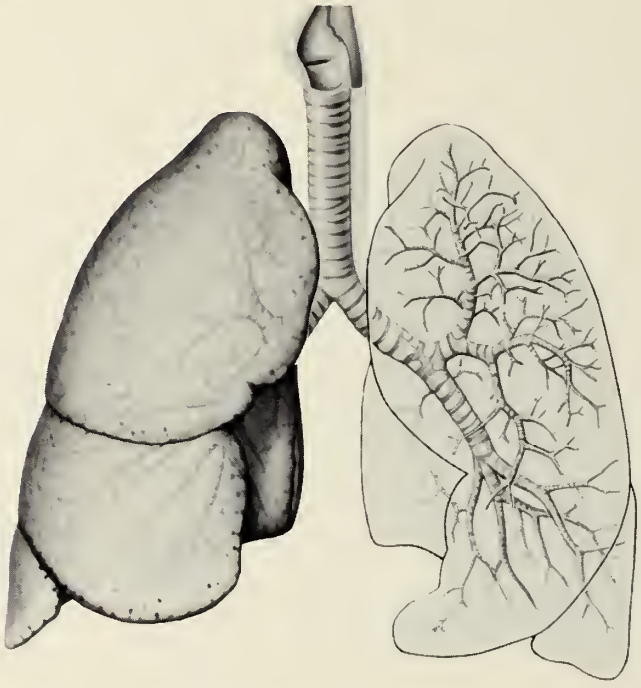
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Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea) 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

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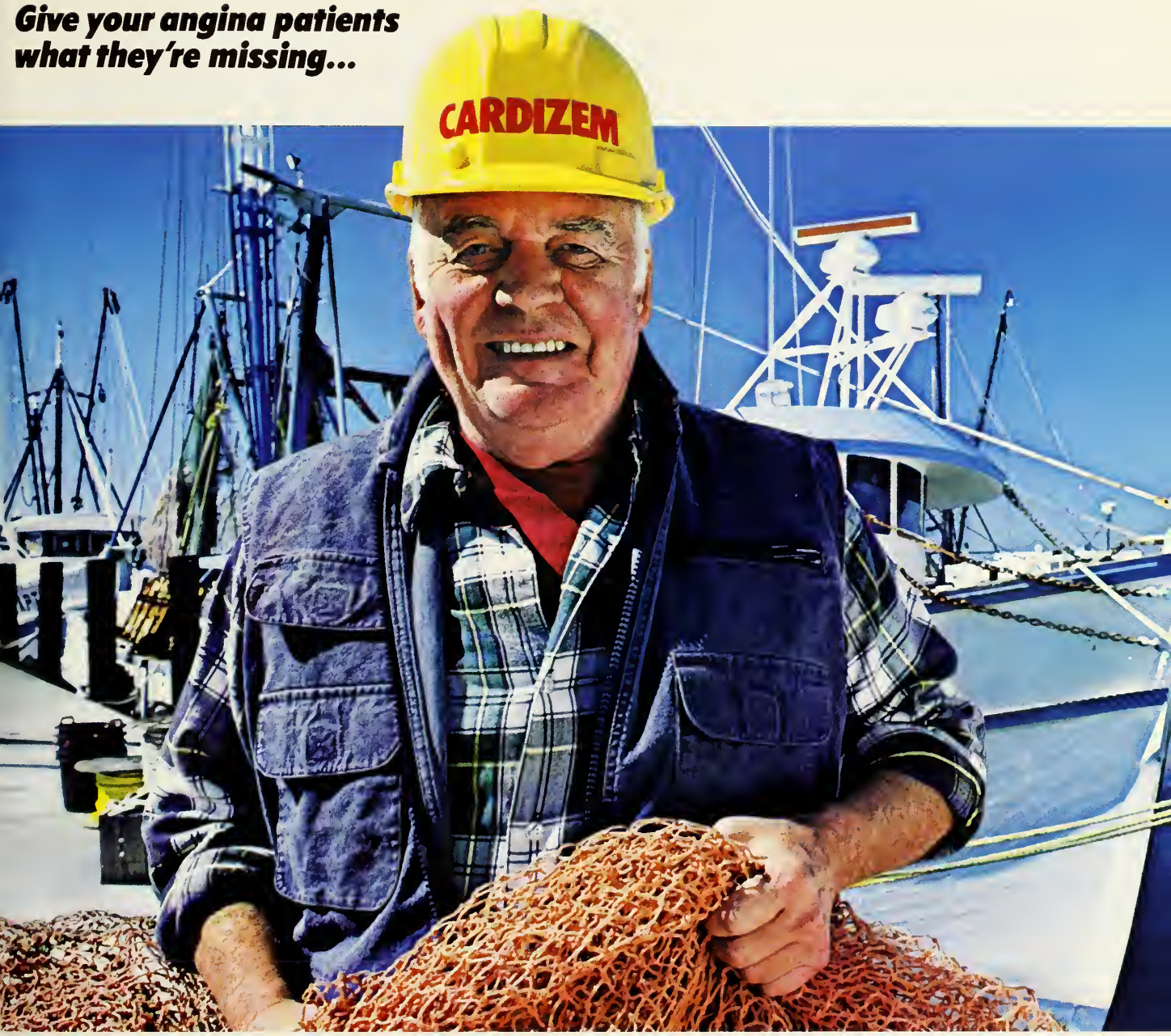
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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 9/86*

See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers. Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris. A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

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To Tier or Not Two Tier

By Daniel A. Deutschman, MD

Editor's note: *The following article is reprinted from the* **Cleveland Physician.** *At the time it originally appeared in print, Dr. Deutschman, a psychiatrist, was serving as president of the Cleveland Academy of Medicine.*

Insurance was originally conceived to protect against loss by spreading the risk of such loss. The risk/loss sharing thus obtained allowed an unexpected financial calamity to be distributed equally among the members of a large group, each of whom suffered only a modest loss.

Competition within the health insurance industry and the rise of alternative delivery systems including the misnamed "health maintenance organizations" has led, however, to a situation in which enrollees are no longer distributed randomly in regard to their health care needs. Some programs have an over-representation of older, less healthy enrollees. Other programs have been designed to attract and retain those least likely to need health care services.

The competitive and alternative delivery approaches grew out of industry's concern with health care expenditures. U.S. industry has had a difficult time competing with industry in Europe and Japan. These new health care systems were designed to reduce utilization of hospital, outpatient, lab and X-ray services. HMOs emphasized prevention, early detection and treatment with the idea that an ounce of prevention is worth a pound of cure.

Our society has long held that self-reliance, hard work, individual initiative and our capitalistic economic system are of great value. However, recently many have begun to feel that high-quality, comprehensive health care is the right of all citizens regardless of ability to pay. The two-tiered system born of this first set of values is unacceptable to the growing number of adherents to this second set of values. They believe quality health care is a right. Denying quality health care to persons without adequate insurance is an anathema to most.

Since many who became ill are no longer able to work, it is only a matter of time before they lose the very health benefits that they enjoyed, but did not need when they were healthy and able to work. Alternative delivery systems push persons who need extensive health care service towards the more traditional indemnity insurance programs because such programs often contain generous benefits. This only makes the maldistribution worse. It becomes even less random than before. Premium costs for the more generous traditional programs soar and many even fully employed persons are unable to afford them. They are left uninsured or underinsured.

Blue Cross and Blue Shield of Northern Ohio is a case in point. It has lost much of its market share. Its ability to provide coverage to the very ill has diminished. Ironically, Community Mutual, BC/BS of Cincinnati, a plan covering a smaller percentage of high risk enrollees has entered this area and has garnered even more of BCNO's group customers. BCNO can no longer shoulder this inequitable burden.

As a potential solution, The American Medical Association has endorsed the concept of risk pooling, an approach tried in several states as early as 1975. Risk pooling is a device designed to return insurance to its original concept, i.e. distribute the risk of loss widely and equitably. Those unable to pay for high cost

"As physicians and as a medical society composed of physicians, we cannot turn our backs on those who are denied access to comprehensive health insurance coverage."

individual policies, sometimes more than 150% of group premiums, have their premiums artificially set between 110% and 125% of the prevailing group policy charges. The difference in premium between the cost to the insurer and the charge to the subscriber is spread equitably among all those with group health insurance coverage.

Risk pooling programs were first introduced in Rhode Island. Since then Connecticut, Minnesota, Wisconsin, Indiana and Florida have adopted such programs. One problem thus far unresolved pertains to self-insured health insurance programs. ERISA guidelines exempt these programs from risk pooling legislation provisions.

The AMA's support of the concept of risk pooling has been strong. Report J of the Council on Medical Services was adopted by the AMA House of Delegates in 1985. It is entitled "Closing the Gaps in Health Care Funding: Use of State Risk Pooling." It calls for health insurance to be made available to individuals at the rates and in the manner outlined above. In most states where risk pooling has been adopted, losses incurred by carriers participating in the pool are credited against premium taxes.

As might be expected, such proposals raise the ire of those who feel it is a form of socialism, a giveaway. They feel, "I worked for mine, why can't they?" Some physicians have felt growing antipathy for BCNO for years. Others say "there are only 600 really sick people in question in this area who would be without insurance if BCNO changed its policy." A few suggest that no solution is needed.

As physicians and as a medical society composed of physicians, we cannot turn our backs on those who are denied access to comprehensive health insurance coverage. While no direct measure of the level of unmet health care need is available, we recognize that without adequate health insurance coverage, some people will defer needed medical attention. This will inevitably lead to more serious illnesses and higher health care costs in the long run. These costs are swollen further if we add in the loss of industrial productivity. Many of the underinsured and uninsured are already being carried by our hospitals and ourselves via uncollectables and bad debts.

As physicians we must be our patients' advocates. The humanitarian issue speaks for itself. No one is immune. We have all noted with chagrin the child who turns 23, the aunt, cousin or parent who suddenly is uninsured or underinsured. The issue is too important to ignore. We must act.

Risk pooling is not a perfect solution. For the time being, self-insured plans will be allowed to escape their share of the burden because of the ERISA regulation. The fact that there is no perfect solution does not mean that we can allow ourselves to turn away from the issue.

What are the alternatives? If no changes are made, some patients will be denied high-quality health care. Others will use physicians' services and leave a trail of uncollected hospital and doctor bills in their wake.

The issue is not what is best for one insurance company or another, but what is best for the citizens of our community, our patients.

The basic issue relates to the question, "do our citizens have a right to high-quality health care?" If the answer is "yes," then a mechanism for funding the insurance premiums of the underinsured must be found. If the problem continues unaddressed, the government will have to step in with another poorly managed bureaucratic approach that will be even more costly and less effective. **OSMA**

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine *or the Ohio State Medical Association.*
Do you have a cause you would like to support? A grievance you wish to air? Why not write a "Second Opinion"? Send your contribution to: The Executive Editor, Ohio Medicine, 600 S. High St., Columbus, Ohio 43215.

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OHIO MEDI-SCENE

Medical student teachers . . . talking to children about sex . . . the top ten prescription drugs . . . operative pelviscopy . . . CHAT-ting in Trumbull County . . .

Medical student teachers

What began as a "germ" of an idea by students at the Medical College of Ohio at Toledo is now a community education program that may be implemented nationwide at medical schools this fall. The program, Student-to-Student, which received funding at the OSMA Annual Meeting in May, has presented health care programs to over 2,000 elementary, junior high and high school students in the past 18 months.

Armed with visual aids such as preserved human organs, slides, and posters, students at MCO present 30-to-40 minute programs to classes in a 90-mile radius of Toledo. Over the last school year, about 60 members of the OSMA Medical Student Section have discussed topics such as the human brain, heart, lungs, the dangers of smoking, the dangers of drugs and alcohol abuse and how to become a medical doctor.



Students from different medical schools around the state met at OSMA's Annual Meeting this year where they presented the Student-Student project to an appreciative House.

The program is the brainchild of MCO students Richard Steinman, David Voight and recent MCO graduate Nick Dewan, MD. It had its beginnings in March of last year, when Voight's wife, Eileen, a fourth grade teacher at Whitehouse Elementary School in suburban Toledo, asked if Steinman could make a presentation to her class. After a quick visit to the MCO anatomy department to procure some human hearts, the program was off the ground. "It went over real well," Steinman recalls. "The kids loved it — and so did the teachers."

Since then, a lot of work has been put into the program. A total of seven presentations have been organized, including one added this past spring — "AIDS: The Facts and the Fiction." Dr. Dewan says the information in this program will have to be updated quite often, as new information on the deadly virus is uncovered. The program has not been presented very many times so far, since it was added to the list late in the school year. Steinman expects the AIDS presentation to be one of

OHIO MEDI-SCENE

Medical student teachers . . . *continued*

the more popular topics in the coming school year, however. "We don't do the AIDS program or the drugs and alcohol much under the junior high level," Steinman says.

At the OSMA Annual Meeting, delegates voted unanimously to donate $1,500 to the effort, which will enable the students to produce additional audiovisual materials to distribute to other Ohio medical schools. Steinman and Dr. Dewan presented the program at the AMA-MSS meeting in Chicago earlier this summer. Dr. Dewan talked on "How to Give a Presentation to Sixth Graders and Up," while Steinman concentrated on the logistics of running the day-to-day operations of such a program.

Most of those participating in the program are first- or second-year students, since those in the upper levels are busy with clerkships and other duties, says Steinman, who is beginning his third year. However, some fourth-year students are expected to participate in the program during the coming year . . . despite their inexperience with the relatively new activity.

"If we can't talk to our patients, we can't deliver good health care."

Yet it is easy to get involved in the project, Steinman claims, since most of the presentational outlines are basic knowledge to medical students, and all they have to do is convey the information in an understandable manner. Students are free to experiment with presentation styles, but they must follow a basic guideline, and all the information they present must be documented.

Following the formal program, a question and answer session reveals what is on the minds of today's young people. For example, Dr. Dewan relates, after a drug and alcohol program last year, one student asked "If my girlfriend is pregnant, how can smoking marijuana affect the baby?" Other questions range from "why do you get addicted?" to "if it's so bad, then why do people do it?" Steinman says the younger children seem to ask more questions than the older ones, since they aren't as worried about being "cool" in front of their peers.

"Sometimes they themselves will have asthma, or know somebody who has emphysema, and they'll ask about that," Steinman says. The topic of cancer also comes up quite frequently.

Another benefit of the program is its help in honing the communication skills of the medical students who participate in it. "When we're trying to get other students involved, we stress that these people, or people like them, are going to be our patients," Steinman says. "If we can't talk to our patients, we can't expect to deliver good health care." He says he has seen people have a hard time when they were practicing a presentation, but when they actually got in front of the kids, they did "a really great job."

He admits that he was a little nervous before his first presentation — "I'd be a liar if I said I wasn't" — but that it soon disappeared. Dr. Dewan says that most of the nervousness comes from self-consciousness, rather than a fear of forgetting what to say. "It's stuff they (the medical students) know pretty well," he says.

MCO students usually go to the schools in teams, making several presentations in a few hours. Although many children have never seen actual human organs before, most are not afraid of them. "Kids are intrigued by them," Dr. Dewan says. So far, children have been able to look at the specimens, but not touch them. But because of the smell of the preserved organs, and for ease of handling, Dr. Dewan says the specimens will be coated with plastic for this year's programs.

Dr. Dewan is pleased with the response from the Toledo community in the program's first full school year. At one high school, three people told him they got more information from the program than they did from any of the national news magazines. Dr. Dewan authored the presentation on drugs and alcohol, a project taking several months of research. Using materials from the National Institute of Drug and Alcohol

Abuse, the Department of Education, and from other national organizations, Dr. Dewan focused the program on how abuse affects bodily functions, such as growth and secondary sex characteristics. "That's pretty important to junior high school students who want to be basketball players," Dr. Dewan adds.

Steinman and Dr. Dewan are optimistic about the possibility of Student-to-Student becoming a nationwide community education program. "In the past, there's been a problem with national (MSS) projects taking too much logistical effort," Dr. Dewan says. "This one doesn't. Everything's been done for them." MCO students plan to make all of their program materials available to any interested medical school. Hopefully, this "germ" of an idea will spread into a nationwide "epidemic" that will educate thousands of children across the country. — *David Sweet*



The top ten prescription drugs

About 1.5 billion drugs are prescribed each year in the United States . . . and, in case you're wondering how this amount breaks down in terms of what is most frequently prescribed, here are some clues from the biostatistics office at the Food and Drug Administration.

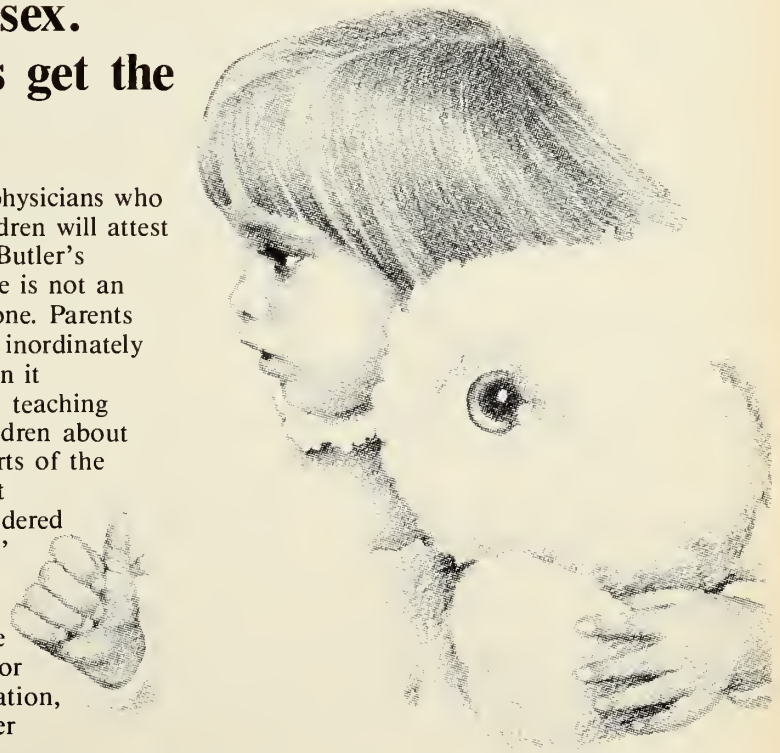
Most drugs — in fact, 332 million prescriptions, or about 20% of all prescriptions written — are used to treat heart attacks, high blood pressure and other cardiovascular conditions.

The second most prescribed group is the anti-infectives and penicillin-type drugs, followed by tranquilizers and (at least for women) the estrogens and progestins — used either alone, for replacement therapy or together as birth control pills.

If it's names you want, however, the FDA points to the following drugs as "the most prescribed." The list reads (in order):

1. **Dyazide**
2. **Lanoxin-brand digoxin**
3. **Inderal**
4. **Valium/Librium**
5. **Tylenol and codeine**
6. **Anoxil**
7. **Tagamet**
8. another diuretic (name not provided)
9. **Davocet-N 100 and**
10. **Motrin**

Talking to children about sex. How you can help parents get the conversation started



As Diane Butler, MD, a Parma Heights pediatrician remembers it, it was one of the most uncomfortable moments in her career.

"I was examining a child and asking questions about whether or not there had been any problems with elimination — was there constipation, diarrhea, that type of thing. The child just looked at me after each question — as though there was no understanding there, no communication. It finally dawned on me that the parents had never discussed the subject of elimination, or at least, the proper terminology for it, with their child. I ended up having to leave the room while they discussed what it was I was trying to find out."

Most physicians who treat children will attest that Dr. Butler's experience is not an isolated one. Parents are often inordinately slow when it comes to teaching their children about those parts of the body that are considered "private." But there are often legitimate reasons for the hesitation, Dr. Butler says.

"Parents may be uncomfortable because they do not have all the facts," she explains. That's the reason she keeps on hand (and

OHIO MEDI-SCENE

Talking to your children about sex . . . *continued*

ready to hand out to patients), a two-page bibliography of books which offer parents advice — and all the facts they need — to have a healthy discussion about sex with their offspring.

Dr. Butler's list includes the name of the book, the book's author, and a library reference number, as well as her own one-paragraph review. For example, in describing a book, "The Flight of the Stork," by Bernstein (library reference number 612.6 B458F), Dr. Butler writes:

"For those who really want to know what THEIR own child is asking at each developmental stage, and who don't mind spending a little more time learning about child development, I heartily recommend this book. It has 175 pages, without a single picture. The author explains in clear detail and in fascinating conversation with children, the six different levels at which children think, regarding sexual information. As children mature, they pass through each level at their own pace, and only by recognizing their present level can you accurately identify what your children really want to know about sex."

Whether or not you wish to go to the same lengths in your prepared bibliographies is up to you, but Dr. Butler does recommend that everyone in the profession who works with children keep such a list handy for parents who "can't teach what they don't know."

Another reason parents are often reluctant to discuss sex with their children is that they are unsure what message they should convey.

"The parents may be unsure of their own feelings on the subject, and, as a result, send a mixed message to their child," explains Dr. Butler. "These messages come out sounding like 'sex is dirty, save it for someone you love.' The child knows that doesn't make sense, and they become very confused."

Often, these children never do get their feelings about sex clear in their own minds, and they pass this same sense of confusion along to their children when they become parents. Over time, the confusion becomes an hereditary, generation-spanning stumbling block.

It doesn't take much observing for physicians to pick up on this "mixed message" confusion in their own examining room, claims Dr. Butler.

"I once had a two-year-old patient who referred to her vagina as her 'naughty-naughty'," she offers in way of example, but more common, she says, are those children who touch a certain area of themselves and instantly trigger an alarm in their parents. These adults, she says, will move over to the child and discreetly pull little Johnny's or Mary's hands away — or they may be more blatant, admonishing the child for what is simply a natural gesture.

Physicians should be alert and sensitive to such situations and use them as opportunities to open up discussions about sexual attitudes, says Dr. Butler.

"I have a tendency to be liberal in terms of the information I give out," she confesses. "I think the more you know about your body, the better off you are. Children who know the correct anatomical names for parts of their body, and who understand the physiology of how their bodies work will turn out to be confident, happy adults."

What type of information or advice does Dr. Butler dispense?

"I have four guidelines," she answers.

First, she tells parents to think twice before answering a child's questions about sex. "Parents need to understand what it is the child is really asking," she points out. By asking the child, "what do you think?" the child will tip you off as to what he or she really wants to know. The classic example of misunderstanding a child's question, of course, is the parent who launches into a detailed

"Children who know the correct anatomical names and understand how their bodies work will become confident, happy adults."

explanation of the birth process when all the child really wants to know by asking "where do I come from" is whether or not he or she is from Columbus or Cleveland.

Second of all, she says, parents should rehearse those issues they want to discuss with the children between themselves. "Role playing will help them get their facts straight, and help them become comfortable with the terminology," she says.

She encourages parents to teach their children to use words like "penis," but because "vagina" is not really a corollary to the male organ ("clitoris comes closest, but that's hard for children to remember and say") she advocates teaching "vulva" instead.

A third guideline she gives parents is "never teach your children anything they must unlearn as an adult." That means all those stories about the stork have to go.

"I also tell parents not to use the word 'stomach' in explaining the birth process. Children know what it's like to have a stomach ache, so they may well interpret birth as a gastrointestinal process." "Uterus" and "womb" are both easy words for children and present a much clearer process of what the birthing process is.

"The information parents give children should be correct," she adds, "even if it's not the whole truth — just a part of it." Of course, how much parents do choose to tell a child depends, to a great extent, on the age level of the child.

By the time a child is three or four years old, for example, Dr. Butler believes he or she should know:

- the correct anatomical names for their sexual parts
- socially acceptable terms for elimination
- that babies grow inside their mother's bodies (the concept of pregnancy)
- the distinction between male and female parts of the body and
- that mothers and fathers together make babies.

"By the time the child is four to eight, however, they are going to need more of an explanation when they ask questions," she continues.

No matter how much a parent chooses to tell a child, however, Dr. Butler encourages them to discuss sex in conjunction with their own sense of morals and values.

"The type of sex education children receive in schools is non-judgmental. It's divorced from any discussion of morality, so it becomes a kind of permissiveness," she says.

That is why some parents have the subtle feeling that any kind of sexual discussion will put ideas in the minds of their children — another reason parents are hesitant to launch into sexual teachings.

"But that's nonsense," Dr. Butler claims. "Studies show this is not true, and, based on my own experience in practice, I know that those adolescent patients who are asking questions about contraception are already sexually active."

That's why physicians need to get conversations between parent and child started, says Dr. Butler.

"If children are forewarned about appropriate sexual behavior, maybe we can prevent some unwanted things — like venereal disease, AIDS, pregnancy, divorce and sexual abuse." — *Karen S. Edwards*

Operative pelviscopy advances gynecological surgery

With the advent of HMOs, DRGs, and other cost control measures, many physicians have been troubled by the fact their patients have to leave the hospital before they are ready.

A Middletown gynecologist, however, has found a way to turn the tables. Using a relatively new surgical procedure called operative pelviscopy, Ralph Kah, MD, allows many of his patients to leave the hospital just hours after what used to be considered major surgery.

"Operative pelviscopy is performing various pelvic procedures through the laparoscope, with secondary incisions," Dr. Kah says. The procedure is fairly uncomplicated, but requires some additional training and good hand-eye coordination. "You make one incision for the optical system (laparoscope), then you make some tiny (5mm) incisions in the superpubic area," Dr. Kah explains. "This allows you to introduce two or three more instruments all at once."

This technique was originally developed in West Germany by Kurt Semm, MD, and has only recently been brought to the U.S. Dr. Kah traveled to the Kiel University Hospital of Gynecology to learn the procedure directly from Dr. Semm himself. Dr. Semm, who designed the 30 or so instruments that can be used with the system, is also an engineer and a veterinarian.

Dr. Kah, who has been doing the procedure for nearly two years now, calls this technique a breakthrough. He recalls a recent operation he performed on a 15-year-old girl, using the techniques. "I took out an ovary — this was on a Wednesday. The next Monday, she was back in school." Dr. Kah says that before this procedure was developed, it was common for such patients to spend four or five days in the hospital and a month at home recuperating.

"This has been the big advantage. When the third parties wake up to it and realize it — they're going to love it," Dr. Kah says. He estimates that 50% of all his surgical procedures now begin as operative pelviscopies. While he is currently one of the few surgeons in the country to practice

OHIO MEDI-SCENE

Pelviscopy advances . . . *continued*

this new procedure, he expects it to become widespread in the future.

"My guess is, especially when you get into the economics of it, that people are going to have this (operative pelviscopy) available in most regional-size hospitals," he says. The new technique can be used for nearly two dozen surgical procedures, with major advantages when it comes to infertility surgery. Standard gynecological procedures are also easier, once the surgeon "gets the hang of it." Dr. Kah uses it for a wide variety of surgeries. "You can remove ovaries, adhesions, take out endometriosis, cysts, remove small fibroids — a lot of tubal work — you can even take out a ruptured ectopic pregnancy," he explains.

One might think that it would be difficult to manipulate the instruments, especially the lasers that can be used in the procedure, once they were introduced into the abdomen. With the standard CO_2 distention of the abdomen, however, Dr. Kah says "you have a panoramic view of pretty much the entire pelvis," and also enough room to work effectively.

The operating time is comparable to that of conventional surgery, once the surgeon is accustomed to the system, Dr. Kah says. "At first, when people start doing it, it takes longer. When you get a little more adept, the time is pretty comparable."

He says that "getting in there and starting the procedure," and when it's over, getting out and closing is a lot shorter with the new system. The advantages don't end there. "The big thing that gets people doing this is the lower morbidity," he says. "You have a much lower infection rate, and it's been pretty well shown that you have a lower rate of adhesion, less irritation and infection."

Since he learned the technique, Dr. Kah, who practices at Middletown Regional Hospital, has increased his patient load and his success rate. With referrals from northern Kentucky, Indiana and other bordering states, he hopes to keep the tables turned on cost containment watchdogs, and keep turning his patients out of the hospital door about a week sooner than if they had undergone conventional surgery. — *David Sweet*



Robert Douglas (left), representing James Traficant, notes a point being made by M. Sorrell, MD (right) while Paul Zerbi, MD, listens.

CHAT-ting in Trumbull County

Editor's note: *This article is not meant to be a definitive piece on the Congressional Health Awareness Tour project in Ohio. Instead, it represents how one county medical society initiated such a program within its own community. Other medical societies may also have begun CHAT projects in their area. This piece is not meant to exclude them.*

As soon as Doris Dean, executive director of the Trumbull County Medical Society received the memo from the AMA about Congressional Health Awareness Tours (CHAT), she was on the phone.

"I recognized how important such a program could be," says Dean, so she called Trumbull County Medical Society President Paul G. Zerbi, MD, and asked him whether or not it was a program he would want to begin in Trumbull County.

It was, so on April 29, the medical society coordinated a meeting between four local physicians (two from each of the local hospitals) and Robert A. Douglas, a representative of Congressman James A. Traficant, Jr., (D-17th District). The purpose of the meeting, Dean explains, was to bring up for discussion issues of concern to medicine — and to

educate at least one member of Congress about the role of doctors in providing care to hospitalized patients.

"Mr. Traficant has gone on record as being opposed to many of health care's propositions," says Dean, so no one knew what to expect when the group gathered around the board table of Trumbull Memorial Hospital that April morning.

"The meeting was loosely structured," Dean admits, and while the half-day gathering did include a brief hospital tour, most of the time was spent in discussion.

Discussion, incidentally, is how the CHAT project differs from the popular mini-internship programs which have recently been adopted by numerous county medical societies around the state. While the internship program links laypeople (in some cases, members of Congress and other political leaders) with mentor-physicians, most of the time in an internship program is spent observing how the physician does his or her job. CHAT, on the other hand, reserves its brief time frame for head-to-head, all-cards-on-the-table discussion — like the one that took place at Trumbull Memorial.

That day, in addition to the four physician-speakers (representing such hospital-based specialties as pathology, radiology and anesthesiology), hospital administrators and nursing personnel from the surgical care and ambulatory care units also came to add their voices to those health care matters being addressed.

Both Dean and Dr. Zerbi were pleased with the results of the first program, and since an ad hoc CHAT committee was already in place, a meeting with Congressman Dennis Eckart (D-11th District) was also arranged. (That meeting took place with his representative, Diane Marchese, on June 2.)

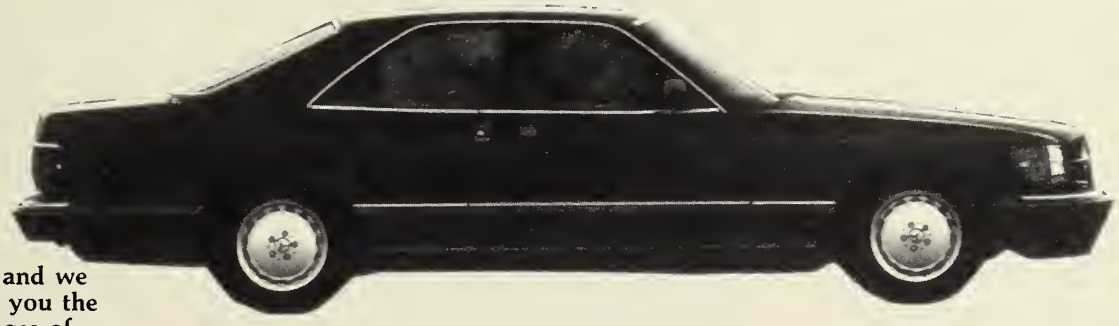
Post-CHAT interviews with the media followed — with both Congressmen's representatives participating.

"I think it's important for members and the public to see that the medical association is trying to do something to make health care better," says Dean.

And, if in the process, it updates legislative representatives in Washington on important health care matters — well, what more could one ask? — *Karen S. Edwards*

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Newly Elected and Re-Elected Councilors

By Susan Porter



J. James Anderson, MD

J. James Anderson, MD

J. James Anderson, MD, has been re-elected Sixth District Councilor of the Ohio State Medical Association, representing physicians in Trumbull, Mahoning, Stark and Columbiana counties.

Dr. Anderson has been in the private practice of pediatrics in Youngstown since 1961. He is a clinical professor of pediatrics at Northeastern Ohio Universities College of Medicine and has been associate director of the Pediatrics Ambulatory Care Center of the Youngstown Hospital Association since 1984. He is a fellow of the American Academy of Pediatrics and a diplomate of the American Board of Pediatrics.

A Youngstown native, Dr. Anderson earned his BA from Ohio Wesleyan University in 1952 and his MD from the University of Cincinnati in 1956. He completed his internship at Youngstown Hospital in 1957 and did his residency in pediatrics at University Hospitals in Cleveland between 1957 and 1959.



John A. Devany, MD

John A. Devany, MD

John A. Devany, MD, has been re-elected Fourth District Councilor of the Ohio State Medical Association, representing physicians in Williams, Defiance, Paulding, Fulton, Henry, Putnam, Lucas, Wood, Ottawa and Sandusky counties.

He is in private practice with the Toledo Otolaryngology Group, Inc. and is on the medical staff at St. Vincent Hospital and Medical Center in Toledo, where he has served as chief of the section of otolaryngology on several occasions. He is also on the active staff at Toledo Hospital and on the courtesy staff at St. Charles Hospital.

A 1955 graduate of the Ohio State University College of Medicine, Dr. Devany did his internship at City Hospital in Akron between 1955 and 1956 and his residency in otolaryngology at the Henry Ford Hospital in Detroit.

He is a past president of the Academy of Medicine of Toledo and Lucas County, and has served on the Academy's Foundation Fund, Judicial and Internal Affairs Commission, Educational and Professional Affairs Commission, and as vice president and a member of Council.

He has served as a delegate to the OSMA since 1973 and is a member of the Committee on Judicial and Professional Affairs.



John F. Kroner, Jr., MD

John F. Kroner, Jr., MD

John F. Kroner, Jr., MD, has been re-elected Eighth District Councilor of the Ohio State Medical Association, representing physicians in Licking, Muskingum, Guernsey, Fairfield, Perry, Morgan, Noble, Athens and Washington counties.

Dr. Kroner has been in private practice in Athens since 1968, where he serves as chief of obstetrics and gynecology at O'Bleness Memorial Hospital. He is certified by the American College of Obstetricians/Gynecologists and is clinical professor of obstetrics/gynecology at the Ohio

University College of Medicine in Athens.

Dr. Kroner served as the OSMA Delegate for Athens County for 10 years and has been active on the OSMA Committee on Education, bringing the first and only CME course to Athens sponsored by the OSMA. He has also served on the Committee on Maternal and Neonatal Health, the Committee on Membership and on the Ad Hoc Committee Review of House of Delegates Policy.

A native of Youngstown, Dr. Kroner graduated cum laude from Ohio University in Athens in 1958 and received his medical degree from Stritch School of Medicine, Loyola University, Chicago, in 1962. He completed both internship and residency at St. Elizabeth Hospital in Youngstown.

He is a past president of the Athens County Medical Society and has served as team physician for Athens High School for a number of years, where he instituted county-wide physicals for high school athletes.

Henry G. Krueger, MD

Henry G. Krueger, MD, is the newly-elected Fifth District Councilor of the Ohio State Medical Association, representing physicians in Cuyahoga, Lake and Geauga counties. He will serve a one-year term to fill the unexpired term of Donavin A. Baumgartner, Jr., MD, the new president-elect of the OSMA.

In private practice since 1953, Dr. Krueger is certified by the American Board of Ob/Gyn and was Chief of Staff at Fairview General Hospital between 1981 and 1983, where he currently serves on the board of trustees and the executive committee.

A 1944 graduate of Temple University Medical School, Dr. Krueger interned at Saint Luke's Hospital in Cleveland and completed residencies in general surgery at Fairview General Hospital and in Ob/Gyn at Saint Luke's.

He is a past president of the Academy of Medicine of Cleveland and served on the Academy's board of directors and executive committee until last year. He is also a delegate from Ohio to the American Medical Association.

Dr. Krueger served as Fifth District Delegate to the OSMA from 1975 through 1987 and has been involved as a member on the Task Force on the Nurse Practice Act.



Henry G. Krueger, MD



William J. Marshall, MD

William J. Marshall, MD

William J. Marshall, MD, has been re-elected Second District Councilor of the Ohio State Medical Association, representing physicians in Darke, Preble, Shelby, Miami, Champaign, Clarke, Greene and Montgomery Counties.

A private practice internist specializing in cardiology, Dr. Marshall is the director of the coronary Intensive Care Unit, the Non-Invasive Cardiac Laboratory and In-Patient Cardiac Rehabilitation at Kettering Medical Center. He is also a clinical professor of medicine at the Wright State University School of Medicine.

Dr. Marshall has served as Second District Councilor since 1984 and has been chairman of the OSMA Legislative Committee since 1985. He is also a member of the OSMA Journal Review Committee and in 1986 was elected to serve as an alternate delegate to the American Medical Association.

A native Ohioan, Dr. Marshall earned his medical degree in 1958 from the University of Maryland and then interned at Philadelphia General Hospital in Pennsylvania before returning to Ohio to serve his residency at the Cincinnati General Hospital.

He is past president of the Ohio Society of Internal Medicine and the Montgomery County Medical Society and has been highly active in numerous organizations in the greater Dayton area. He presently is chairman of the Montgomery County Medical Society's Mini-Internship Committee and is the current president of the Dayton Society of Internal Medicine.

H. William Porterfield, MD

H. William Porterfield, MD, has been re-elected Tenth District Councilor of the Ohio State Medical Association, representing physicians in Morrow, Knox, Union, Delaware, Madison, Franklin, Fayette, Pickaway and Ross Counties.

Dr. Porterfield is president,

continued on next page

chairman of the board and chief executive officer of Physicians Health Plan of Ohio, a non-profit HMO-IPA owned by the Academy of Medicine of Columbus and Franklin County.

In August of 1986, Dr. Porterfield retired from an active practice with Ohio Plastic Surgeons, Inc., in Columbus, after 26 years with that group.

Dr. Porterfield served as an OSMA Delegate from 1968 to 1982 and was chairman on the OSMA Committee on Government Medical Care Programs from 1966 through 1973. He was on the OSMA Ad Hoc Committee on Health Care Delivery between 1974 and 1976 and has served as 10th District Councilor since May of 1985.

A native of Hagerstown, Maryland, Dr. Porterfield graduated from Jefferson Medical College in Philadelphia and did his internship and general surgery residency at Akron City Hospital. His plastic surgery residency was completed at the University of Indiana Medical Center in Indianapolis.

Dr. Porterfield is a past president of the Academy of Medicine of Columbus and Franklin County and he currently serves as a delegate to the American Medical Association.



H. William Porterfield, MD



Jack L. Summers, MD

Jack L. Summers, MD

Jack L. Summers, MD, has been elected the new Twelfth District Councilor of the Ohio State Medical Association, representing physicians in Summit and Portage counties.

Dr. Summers is a professor of urology at Northeastern Ohio Universities College of Medicine and is clinical professor of urology at West Virginia University School of Medicine. He is an adjunct professor at the Institute for Bio-Engineering at the University of Akron; chairman of the Department of Urology at Akron City Hospital and chairman of the Council of Urology at NEOUCOM.

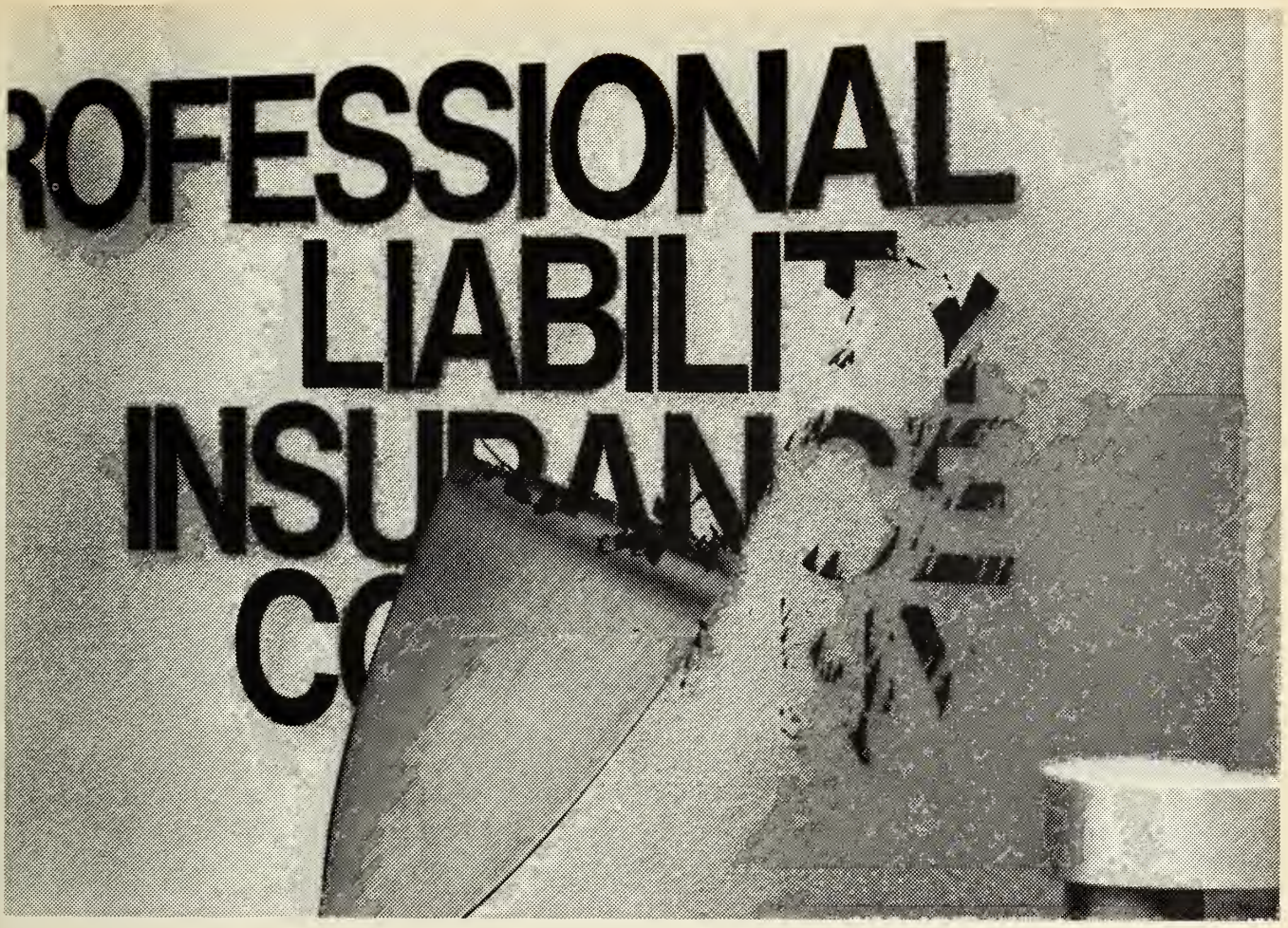
Dr. Summers has served two years on the OSMA Legislative Committee and joined the OSMA AIDS Task Force in 1987, as well as the Northeast Ohio AIDS Task Force.

He is secretary of the Summit County Medical Society and is a past president of the Summit County Medical Society. Other activities include the OMPAC Board of Directors, 1985-present; the OSMA Executive Committee; and Councilor of the Summit County Medical Society from 1980 to the present. He served as the OSMA Delegate from Summit County from 1978 through 1987.

A native of West Virginia, Dr. Summers graduated from the West Virginia School of Medicine in 1966 and did his internship and general surgery residency at Akron City Hospital, where he also completed a urology residency in 1973. He has been active in the private practice of urology in Akron since that time.

Dr. Summers is a past president of the Cleveland Urological Society and the Ohio Urological Society. He was recently elected an alternate delegate to the American Medical Association.

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OMPAC



The Ohio General Assembly and U.S. Congress considered more than 100 pieces of legislation directly affecting medicine during the first half of 1987 -- and OMPAC proved to be a significant force in seeing that the views of Ohio's physicians were heard. Although we scored some major victories in the Statehouse, many more bills will be before the legislature as we approach 1988.

Each year the issues facing medicine become more significant. Each year we face tougher legislative battle against well-financed and vocal opponents. And each year we need the support of every physician in Ohio.

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A Mid-Year Legislative Report

By OSMA Department of Legislation

The Ohio General Assembly, before adjourning for summer recess on June 30, 1987, sent 100 bills to the Governor for action, completing what should be the busiest segment of the first year of the 117th General Assembly's biennial session. The Ohio House of Representatives saw 71 of the 584 bills its members introduced be enacted, while 29 of the 261 bills introduced in the Ohio Senate were approved and forwarded to Governor Celeste. Of these approximately 800 bills considered by the Ohio General Assembly, the OSMA Legislative Department actively monitored and effectively represented organized medicine's views on the nearly 100 bills which impact health care and the practice of medicine.

The first six months of this legislative session found the Ohio State Medical Association's legislative staff committing countless hours and considerable energy making certain that any legislation which might be passed by the General Assembly would not adversely affect Ohio's physicians and the quality of health care in this state. The overwhelming response by Ohio's physicians in contacting their local legislators contributed significantly in the OSMA's efforts on many important bills. This groundswell of physician support proved invaluable for the successes achieved for organized medicine in the Ohio General Assembly.

Some of the more important pieces of legislation under review the first six months included: medical professional liability reform, Medicare assignment, certificate of need, and revisions to the Nurse Practice Act. These issues and many others are described in this article.

The priority item on the OSMA's legislative agenda for this session was passage of **House Bill 327,** the medical professional liability reform bill. The measure was sponsored by State Representative Paul Jones of Ravenna and State Senator David Hobson of Springfield, chairmen of their respective chamber's Health Committee. House Bill 327 was passed by the Ohio House of Representatives (83-7) and the Ohio Senate (32-1) by overwhelming margins and was signed into law by Governor Richard Celeste. However, passage of the bill was not without considerable opposition from the Ohio Academy of Trial Lawyers and the Ohio Public Interest Campaign, a Nader-type consumer group. Passage was achieved only after lengthy negotiations on the part of the OSMA, the leadership of the Ohio General Assembly and representatives of the opposing groups. The bill becomes effective on October 20, 1987.

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The tremendous response of individual physicians to contact state legislators in support of House Bill 327 was the key to OSMA's legislative campaign . . .

House Bill 327 was key in OSMA's legislative campaign to gain passage of this significant piece of legislation. The impressive volume of letters and telephone contacts generated by Ohio's physician community highlighted the importance of this issue to the members of the Ohio General Assembly and the Governor.

Passage of House Bill 327 should be viewed by Ohio's physicians as a significant victory. The important changes achieved in the bill are meaningful, not only in respect to the positive impact they will have on the volume of medical professional liability cases and the medical liability insurance market, but also in regards to the achievement of these changes in the volatile political environment in which such was accomplished. Few additional changes in general tort law for any other profession or group may be as significant.

Physicians are encouraged to contact their state representatives and state senators, especially Representative Jones and Senator Hobson, thanking them for their consideration of this very important issue. For more information regarding the provisions in House Bill 327, please see page 595.

Mandatory Assignment Bill Remains in Subcommittee

A major legislative priority this session has been **House Bill 150** which would require a physician who provides health services to a Medicare patient to accept Medicare assignment or face the possibility of licensure revocation by the State Medical Board. House Bill 150 is almost identical to the legislation which passed the State of Massachusetts in 1985. When the legislators adjourned for their summer recess, House Bill 150 remained in a subcommittee of the Ohio House of Representatives Aging and Housing Committee. The volume of letters written by physicians in opposition to House Bill 150 were extremely helpful in keeping this bill in the subcommittee.

Physicians who testified before the full committee and the subcommittee in opposition to House Bill 150 include: John E. Albers, MD (Cincinnati), Donavin A. Baumgartner, Jr., MD (Cleveland), Wilma Bergfeld, MD (Cleveland), Janet K. Bixel, MD (Columbus), Daniel Deutschman, MD (Cleveland), Luana J. Hess, MD (Bowling Green), Frederick Karaffa, MD (Granville), Charles M. Katz, MD (Columbus), Frederic Lafferty, MD (Cleveland), Sue Leatherman, MD (Columbus), Michael F. Lehv, MD (Columbus), Herman Menges, Jr., MD (Cleveland), Ralph G. Roehner, Jr., MD (Columbus), David Spriggs, MD (Canton), Fredrick Suppes, MD (Cleveland), and Claire Wolfe, MD (Columbus).

Revisions to the Nurse Practice Act

House Bill 529, sponsored by State Representative Judy Sheerer (D-Shaker Heights), would revise the statutes governing the practice of nursing. Although House Bill 529 was not introduced until early June 1987, negotiations began on this bill months before introduction. State Representative Sheerer, wanting to avoid the controversy surrounding House Bill 315 in the 116th General Assembly, began meeting with all interested parties to this bill in early spring.

The Ohio State Medical Association was able to keep out of House Bill 529 all the controversial provisions which were a part of last year's bill. This includes "nursing diagnosis," prescription authority for nurses, extensive expansion of the scope of practice of registered nurses, creation of a nursing council to delineate the function of advanced registered nurse practitioners, and the repeal of the prohibition on nurses practicing medicine.

House Bill 529 was voted out of the Ohio House of Representatives 97-0 at the end of June and will now be referred to a committee in the Ohio Senate for consideration. Major provisions included in House Bill 529 would:

1. redefine the scope of practice of registered nurses and licensed practical nurses;
2. revise the prohibition on nurses practicing medicine;
3. expand the grounds for the State Nursing Board to discipline nurses;
4. provide title protection for certified registered nurse anesthetists;
5. place licensure of nurse midwives under the State Nursing Board;
6. revise the composition of the State Nursing Board by adding two additional registered nurses and a public member;
7. require 24 hours of continuing education for nurses every two years;
8. allow the State Nursing Board

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H.B. 327: The medical professional liability reform bill

House Bill 327, the medical professional liability reform bill which passed the Ohio General Assembly, offers statutory changes needed to help stabilize the medical liability insurance marketplace, helping to ensure affordable and accessible liability insurance. This is imperative so that the high-quality medical care enjoyed by Ohio citizens can continue unaltered.

The major provisions in the bill include:

Statute of Limitations — A more definitive statute of limitations continues to be the most important element needed to stabilize the cost and availability of health care in this state. For an injured adult, the bill retains current procedures which permit a suit to be filed up to one year from the date of the discovery of the injury, with a four-year limit from the date of injury.

For minors, the new provisions established in the bill will do much to protect Ohio physicians from the endless threat of being sued. As passed, the bill separates claims brought by parents on behalf of their injured children from the claims brought by parents on their own behalf as the result of an injury to a child. These claims brought by parents on their own behalf are legally known as derivative claims. Derivative claims include claims for medical expenses and other expenses incurred by the parents for the care of the child, as well as the parents' non-economic damages. In most cases, derivative claims constitute the largest portion of the claims for children, due to the fact that parents are legally responsible for the care and support of their children.

Derivative claims would be subject to the same statute of limitations as is now applicable to any adult medical claim — up to one year from the discovery of the injury, with a four-year limit from the date of the injury. However, parents would be permitted to bring suit on behalf of their injured child until his or her 19th birthday, if the injury was discovered prior to the 18th birthday. For injuries to a minor discovered after the 18th birthday, the injured party has one year from the date of discovery of the injury, with a maximum of the 22nd birthday. The suits filed under this statute could only be filed for damages to the minor, such as "pain and suffering," that are not the responsibility of the parents. The statutory cap on "pain and suffering" remains unchanged at a maximum of $200,000.

This provision reflects the position taken by legislative leaders that at this time any effort to shorten the period in which a minor can bring his or her own claim would be unconstitutional due to recent decisions by the Ohio Supreme Court.

Periodic Payments — The bill provides for the *mandatory* periodic payment of certain future damages, when these damages are in excess of $200,000, and requested by either party in the suit. This *mandatory* provision for periodic payments has been granted specifically to medical claims.

Frivolous Suits — In an effort to reduce the number of frivolous suits, the legislation provides that following the review of the case by a physician, an affidavit be filed certifying the merit of a case. The penalty for the filing of a false affidavit includes the assessment of the defendant's costs and attorney's fees against the plaintiff, his attorney, or both.

Penalties for Frivolous Conduct — In any malpractice action where the court determines there has been frivolous conduct on the part of the plaintiff or his/her legal counsel, the court may award attorney's fees to the defendant.

Immunity for Non-Profit Hospital Officers, Trustees and Volunteers — Any non-profit hospital officer, trustee, or volunteer who does not receive compensation will not be liable in a tort action for negligence unless the action was willful or wanton.

Arbitration — The bill would make arbitration permissive and non-binding. Any arbitration awards would not be admissible as evidence in subsequent litigation.

Physicians are encouraged to contact their state representatives and state senators, thanking them for support on House Bill 327.

Study Commission — In order to monitor the impact of the bill, a legislative study commission will be established to determine the success of this bill in achieving its goals and to indicate if further statutory changes are

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The OSMA was able to keep out of the Nurse Practice bill all the controversial provisions which were a part of last year's bill.

to establish specialty certification criteria by rule for registered nurses with advanced education and experience; and

9. require the reporting of nurses whose employment was terminated for conduct that would be grounds for disciplinary action by the State Nursing Board.

Medicaid Provider Reimbursement Fee Increase

The state's 1988-1989 biennial budget was passed one day prior to the June 30 deadline during the waning days of the Ohio General Assembly. Passed on a predominantly party-line vote, the bill appropriates $22.5 billion for state general operations over the next two years. **The OSMA worked closely with the legislature and the administration to retain a 4% Medicaid provider reimbursement increase in the Department of Human Services budget effective January 1, 1989.** This increase is significant in that few other budget items received any greater increase.

Certificate of Need

House Bill 499 re-enacts the Certificate of Need Law and extends Ohio's CON program for two years until June 30, 1989. Sponsored by the chairmen of the health committees in the Ohio General Assembly, House Chairman Paul Jones of Ravenna and Senate Chairman David Hobson of Springfield, the bill was the culmination of months of hearings before a CON Study Committee, which State Senator Hobson also chaired.

As introduced, House Bill 499 may have subjected physicians' offices to CON review because the bill would have required review for "any person" expending $1.5 million or more for capital improvements or $500,000 or more in operating costs to provide a new health service. OSMA succeeded in exempting physicians' offices by making those triggers applicable to "health care facilities" rather than to "any person." Physicians' offices are specifically exempt from the statutory definition of a health care facility. However, any acquisition of medical equipment valued at $750,000 or more would be subject to review regardless of location.

The bill was also amended to clarify a provision which would have required review of any expenditure, regardless of the amount, for megavoltage radiation therapy services. An OSMA amendment clarified that the review applies only to those megavoltage radiation therapy services which are operated by or on behalf of a health care facility.

House Bill 499 became law on June 30, 1987, upon the signature of the Governor. In coming months, the OSMA will closely monitor the promulgation of administrative rules as the Department of Health begins to implement this new CON law.

Legislation to Regulate Generators of Infectious Solid Wastes

After many months of meeting with interested parties, two Republican members of the Ohio House of Representatives, Samual Bateman of Milford and JoAnn Davidson of Columbus, have introduced **House Bill 550, a comprehensive bill to regulate the disposal of infectious solid wastes.** Identical legislation, **Senate Bill 243,** has also been introduced in the Ohio Senate by State Senator Gary Suhadolnik, who is the Chairman of the Ohio Senate Energy, Natural Resources and Environment Committee. Both House Bill 550 and Senate Bill 243 had initial hearings in their respective committees before the legislature began its summer recess.

The Ohio State Medical Association was able to obtain an exemption from disposal regulations for physicians and other generators who produce fewer than 50 pounds of infectious solid wastes during any one month. The small generator exemption applies to the disposal of sharps that are packaged in rigid, tightly closed, puncture resistant containers that are capable of resisting crushing when compacted and that are labeled "sharps" if treated, and labeled with the international biohazard symbol, if untreated. Specimen cultures and cultures of viable infectious agents would be required to be disinfected by the small generator before being disposed of with the regular waste.

Physicians are encouraged to contact members of the Ohio House of Representatives Energy and Environment Committee and the Ohio Senate Energy, Natural Resources and Environment Committee to explain why small generators of infectious waste should be exempt from the regulations provided for in House

Bill 550 and Senate Bill 243. **The Ohio Hospital Association will be working to eliminate the small generator exemption from the bill since its Board of Trustees voted to oppose the small generator exemption.**

The OSMA Legislative Committee has appointed a subcommittee consisting of Robert E. Schulz, MD (Wooster), Edmond W. Gardner, MD (Columbus), and Lee W. Like, MD (Lima), to review this legislation.

Allied Practitioners

As usual, a number of pieces of legislation have been introduced pertaining to allied practitioners. **House Bill 393,** sponsored by State Representative Ronald Mottl (D-Parma) and supported by the Ohio State Medical Association, would prohibit "medical quackery" or the practice of fringe medicine and would establish penalties. House Bill 393 has passed the Ohio House of Representatives and has been referred to the Ohio Senate for consideration.

In another bill, hospitals would be required to grant chiropractors access to those hospital outpatient diagnostic services which are within the chiropractor's scope of practice. **House Bill 149,** sponsored by State Representative Barbara Pringle (D-Cleveland), was referred to the House Health and Retirement Committee where it remains.

Legislation to provide hospital staff privileges for psychologists has returned this session, this time as **House Bill 460** sponsored by State Representative C.J. McLin (D-Dayton). House Bill 460 would prohibit the governing board of any hospital from discriminating against a psychologist in acting upon applications for staff membership and privileges. The bill remains in the House Health and Retirement Committee.

House Bill 257 would require the registration of every homemaker-home health agency which accepts public funds and operates in a county with a population of 65,000 or more. Sponsored by State Representative Paul Jones (D-Ravenna), the bill has not yet received hearings in the House Health and Retirement Committee.

Anesthesiologists have concerns about a provision of House Bill 526, legislation which generally revises the Ohio Dental Practice Act. The provision of concern involves the issuance of permits from the Ohio Dental Board for dentists who wish to employ conscious intravenous sedation. House Bill 526 is being heard before a subcommittee of the House State Government Committee.

In other legislation, a handful of mechanotherapists would benefit from a bill authorizing insurance payments be made directly to them for mechanotherapy services. Senate Bill 176 passed the Ohio Senate Health, Human Services and Aging Committee.

Although legislation has not yet been introduced to license radiation technicians and respiratory therapists, these bills are expected to be introduced later in the 117th Ohio General Assembly.

Mandates on Medical Practice

In addition to **House Bill 150,** the Medicare assignment legislation, the certificate of need review legislation and legislation to regulate the disposal of infectious waste, a number of bills have been introduced which place mandates on the practice of medicine.

House Bill 215, sponsored by State Representative Francine Panehal (D-Cleveland), would require a physician to provide information on the alternative treatments of breast cancer prior to a patient consenting to treatment for breast cancer. House Bill 215 would also create a Cancer



Herman I. Abromowitz, MD

The OSMA Committee on Legislation

The OSMA legislative staff worked closely with the association's Committee on Legislation to analyze bills to ensure that their effect would not impair Ohio's physicians from delivering quality health care services to the citizens of Ohio. The OSMA's Committee on Legislation is chaired by Herman I. Abromowitz, MD, of Dayton. Members of this committee include: Janet K. Bixel, MD (Columbus); John A. Burkhart, MD (Columbus); James W. Cottrell, MD (Steubenville); Nicholas G. DePiero, MD (Brecksville); Daniel A. Deutschman, MD (Cleveland); Philip T. Doughten, MD (New Philadelphia); Antoinette P. Eaton, MD (Columbus); Edmond W. Gardner, MD (Columbus); Karen V. Guss, Medical Student (Toledo); Thomas J. Hall, MD (Newark); Konrad F. Kircher, MD (Dayton); John F. Kroner, Jr., MD (Athens); Lee W. Like, MD (Lima); Stanley J. Lucas, MD (Cincinnati); William J. Marshall, MD (Dayton); Mrs. Sue Massie, OSMA Auxiliary (Ironton); William C. Miller, MD (Cincinnati); Maurice E. Mullet, MD (Berlin); W. Scott Nekrosius, MD (Dayton); John W. Ray, MD (Zanesville); Victoria Ruff, MD (Columbus); Richard D. Ruppert, MD (Toledo); Robert E. Schulz, MD (Wooster); Jack L. Summers, MD (Tallmadge); Steven Swedlund, MD (Bellevue); Miller F. Toombs, MD (Wheelersburg); Albert L. Tsai, MD (Ravenna); Mrs. Rose Vesper, OSMA Auxiliary (New Richmond); George F. White, MD (Portsmouth) and Richard A. Wiseley, MD (Toledo).

Treatment Advisory Committee to assist the Ohio Department of Health in preparing a standardized written summary on the alternative treatments for breast cancer and would require a "consent for breast biopsy" form and a "consent for breast cancer surgery" form to be signed by the patient prior to an operation for a tumor of the breast. House Bill 215 has been undergoing hearings in the Ohio House of Representatives' Aging and Housing Committee. Members of the Ohio Chapter of the American College of Surgeons who have testified on this bill include: Richard Reiling, MD (Dayton), John P. Minton, MD (Columbus), Prabir Chaudhuri, MD (Toledo), and Margaret Dunn, MD (Dayton). Discussions are still underway between members of the Ohio Chapter of the American College of Surgeons and the sponsor of the legislation.

House Bill 273, sponsored by State Representative Marc Guthrie of Newark, makes changes in Ohio's existing statutory requirement for the reporting of certain burn injuries. The bill becomes effective September 10, 1987. Since 1975, Ohio physicians have been required by statute to report to law enforcement authorities "any second or third degree burn that was inflicted by an explosion or other incendiary device, or any burn that shows evidence of having been inflicted in a violent, malicious, or criminal manner." House Bill 273 revises that reporting statute so that a physician, nurse or limited practitioner who attends to or treats a person for a burn injury outside of a hospital, sanitarium, or other medical facility must report that burn injury to a local arson bureau, if applicable, or to local law enforcement authorities if the burn injury was inflicted by an explosion or other incendiary device, or that shows evidence of the burn injury having been inflicted in a violent, malicious, or criminal manner. The bill limits the reportable burns by defining a "burn injury" to mean a second or third degree burn, any burn to the upper respiratory tract or laryngeal edema due to the inhalation of super-heated air, or any burn injury or wound that may result in death. The reporting requirement is also placed on the manager, superintendent or any other person in charge of a hospital, sanitarium or other medical facility where a burn injury is treated.

Additionally, the person making the local report must also submit a written report to the state fire marshal on a form provided by the state fire marshal within three working days after attending to the victim. The legislation also includes immunity from criminal or civil liability which might arise as a result of such action for those individuals making the reports. This immunity language closely resembles the immunity language currently in effect for Ohio's child abuse reporting statutes.

The penalty for *negligently* failing to notify authorities of a reportable burn injury is a minor misdemeanor (maximum $100 fine), a lesser penalty than now exists. However, if a person *knowingly* fails to report such a burn injury, the current penalty of a second degree misdemeanor applies.

House Bill 500, sponsored by State Representative Barbara Pringle (D-Cleveland), would require nursing homes to allow a patient or, if the patient is deceased, the patient's designated sponsor or the executor of the patient's estate, to examine or obtain a copy of a medical record covering the patient's prior residency in the nursing home. State Representative Pringle sponsored a similar bill in the 116th General Assembly. House Bill 500 has been referred to the Ohio House of Representatives' Health and Retirement Committee.

State Senator Grace Drake of Solon has sponsored **Senate Bill 77,** legislation to require the hearing screening of each newborn housed in a hospital nursery through a high-risk questionnaire to determine if the infant meets hearing impairment criteria established by the Ohio Department of Health. All newborns determined to be at risk shall have provided by the hospital a hearing assessment performed by or under the supervision of an audiologist, neurologist or otolaryngologist. If the hospital does not provide the assessment, it shall provide a list of facilities where such assessments can be provided.

The hospital in which the hearing screening questionnaire is completed must notify the infant's primary care physician and the Ohio Department of Health of the infant's name if the infant is identified at risk for hearing impairment. This notification requirement also applies if the infant is identified as hearing impaired following the hearing assessment.

The OSMA and the Ohio Chapter, American Academy of Pediatrics has worked closely with Senator Drake on this bill. The bill is currently before the Ohio Senate Finance Committee for review of an appropriation included in the measure.

Health Care Programs

A few bills have been introduced in the 117th Ohio General Assembly creating health care programs or affecting existing health care programs.

Senate Bill 16 was introduced by State Senator Michael White (D-Cleveland) to create the Pharmaceutical Assistance for the Elderly Program. This program would enable certain low-income

individuals 62 or older, who do not receive Medicare or Medicaid, to receive certain drugs at a greatly reduced rate. This bill has been referred to the Ohio Senate Health, Human Services and Aging Committee.

Two bills introduced to provide former recipients of Aid to Dependent Children or Poor Relief with medical assistance are **House Bill 382,** sponsored by State Representative Michael Verich (D-Warren), and **Senate Bill 241,** sponsored by State Senator Charles Horn (R-Dayton). House Bill 382 has been undergoing hearings in the Ohio House of Representatives' Human Resources Committee and Senate Bill 241 has been referred to the Ohio Senate Economic Development and Small Business Committee.

A bill to allow the Ohio Department of Human Services to audit Medicaid providers and to allow the Department to withhold certain payments to Medicaid providers during an audit appeal has passed the Ohio General Assembly. **Senate Bill 196,** sponsored by State Senator David Hobson (R-Springfield) would also enable the Department to terminate a Medicaid provider agreement immediately upon the conviction of or entry of a judgment against a Medicaid provider. The Ohio State Medical Association was successful in amending Senate Bill 196 to provide for physician due process rights during the Department's audit. An identical bill, **House Bill 479** sponsored by State Representative Paul Jones of Ravenna, passed the Ohio House of Representatives, but will not be considered by the Ohio Senate since Senate Bill 196 passed both houses.

AIDS Legislation

A number of bills have been introduced in the General Assembly concerning AIDS and other contagious and infectious diseases. As a result of these bills, the Ohio House of Representatives and the Ohio Senate appointed a 14-member task force to deal with the social and legal problems associated with AIDS. **The AIDS Task Force** is chaired by State Senator David Hobson (R-Springfield), Chairman of the Ohio Senate Health, Human Services and Aging Committee. Legislators appointed to the AIDS Task Force include: State Representative Paul Jones (D-Ravenna), Chairman of the Ohio House of Representatives' Health and Retirement Committee, and State Representative Robert Doyle (R-Beavercreek) and State Senator Michael White (D-Cleveland), the ranking minority members of the House and Senate Health Committees. Physicians appointed to the AIDS Task Force include OSMA members: Carlos Andarsio, MD (Springfield), Earl Freimer, MD (Toledo), and Leonard Calabrese, DO (Cleveland). The AIDS Task Force will be reviewing legislation introduced in the General Assembly pertaining to AIDS.

A number of bills have been introduced this legislative session on infectious and contagious diseases. State Representative Larry Adams (R-Marion) has introduced **House Bill 571,** which would prohibit any person, with knowledge that he is an AIDS virus carrier, from selling or donating his blood, if he knows or should know that the blood is being accepted for the purpose of a transfusion to another individual. Violations of this provision would be a felony of the third degree. House Bill 571 has been referred to the Ohio House of Representatives' Judiciary and Criminal Justice Committee.

House Bill 199, sponsored by State Representative John Stozich (R-Findlay), would require applicants for a marriage license to be tested for syphilis and AIDS prior to filing for a marriage license. **House Bill 212,** sponsored by State Representative Marie Tansey (R-Vermilion) would require the attending physicians to report immediately to the hospital authority if he knows or has reason to believe that a person who died in a hospital died of, or was under treatment for AIDS or asiatic cholera, yellow fever, diphtheria, typhus, typhoid fever, or any other contagious or infectious disease. House Bill 212 would also prohibit the hospital from releasing the body to a funeral director until such person acknowledges that he has been informed that the person died of, or was under treatment for AIDS or any other contagious or infectious disease. Both House Bill 199 and House Bill 212 have been referred to the Ohio House of Representatives' Health and Retirement Committee.

A bill very similar to House Bill 212 is **Senate Bill 258** sponsored by State Senator Robert Ney (R-Barnesville). This bill would require the attending physician or coroner who has responsibility for signing the medical certificate of death to notify the funeral director of any contagious or infectious disease the deceased person had prior to receipt of the body.

State Representative Don Gilmore (R-Columbus) has introduced two bills pertaining to contagious or infectious diseases. **House Bill 551** would require a coroner to perform one or more laboratory tests for human immunodeficiency virus antibodies (HIV) on each body that the coroner takes charge of. House Bill 551 has been referred to the Ohio House of Representatives' Health and Retirement Committee. State Representative Gilmore's other bill, **House Bill 538,** would require an employee of a food service operation to procure a food handler permit. As part of the

"Ohio physicians should be proud of the OSMA's legislative accomplishments. From medical liability to mandatory assignment to the nurses' bill, physicians' views were well represented in the 1987 session." — Herman I. Abromowitz, MD, OSMA Legislative Committee Chairman

application process and renewal process for the food handler permit, the applicant would be required to have a blood test to determine whether the applicant has an infectious or contagious disease, i.e. tuberculosis, syphilis or AIDS. An applicant with an infectious or contagious disease would be denied a permit and would be advised to seek medical attention. House Bill 538 has been referred to the Ohio House of Representatives' State Government Committee.

Health Facilities

In addition to the passage of **House Bill 499** extending the Ohio Certificate of Need program, several other bills passed which broadly impact health care facilities.

House Bill 86, which becomes effective on October 1, 1987, requires hospitals to report certain patient data information to the Department of Health and make the information available to the public. House Bill 86 was sponsored by State Representative I. Ray Miller (D-Columbus). A companion bill **Senate Bill 126** introduced in the Ohio Senate would have required physicians to post a sign in their office notifying patients that a list of physician fees was available. OSMA succeeded in removing the physician mandate from Senate Bill 126, and OSMA amended other provisions of the bill to assure patient and physician confidentiality.

When State Representative Paul Jones introduced **House Bill 440,** it would have exempted freestanding child and adolescent psychiatric facilities from any Certificate of Need review. The bill met fierce opposition while being heard before the Ohio House of Representatives' Health and Retirement Committee. In response to that opposition the bill was compromised to the satisfaction of most involved in the debate. Rather than an exemption, the bill provided for special CON review process for the development of a limited number of child and adolescent psychiatric facilities. The Director of Mental Health may grant certificates of need for the establishment and construction of these facilities after conducting a review based on specific criteria. The compromised language was taken from House Bill 440 and placed in House Bill 499, the CON bill, where it passed and became effective on June 30, 1987.

House Bill 266, introduced again in 1987 by State Representative Joan Lawrence (R-Galena), would require autopsies to be performed when a child under the age of one dies suddenly when in apparent good health. This bill would also require the local health department to offer counseling or other supportive services it has available to the parents or guardians of the child and require the local health department to offer the parents or guardians information about sudden infant death syndrome.

As a result of the Governor's Task Force on Adolescent Sexuality and Pregnancy, chaired by Antionette Eaton, MD (Columbus), State Representative Jane Campbell (D-Cleveland) introduced **House Bill 345.** This bill would establish an **Adolescent Pregnancy Prevention Grant Program** to encourage the providing of adolescent pregnancy prevention programs. This bill would also create an Adolescent Pregnancy Prevention and Pregnancy Services Board to administer the grant program and would create a Citizens' Advisory Council to the Board. House Bill 345 does provide that no funds received through a grant are to be used for providing or promoting abortion services. This bill would require local boards of education to institute "human growth and development" courses in grades kindergarten through grade 12. This bill would also require health care insurance policies to provide coverage to a newborn child of the subscriber's dependent child. This bill was referred to the Ohio House of Representatives' Children and Youth Committee, where the bill was placed in a subcommittee and revised and voted back to the full committee.

State Representative Judy Sheerer (D-Shaker Heights) and State Senator Richard Schafrath

(R-Loudonville) have introduced in their respective houses legislation to **prohibit the use of corporal punishment in public schools** as a means of disciplining a child. Pursuant to the OSMA Amended Resolution 39-83, the OSMA supports the abolition of corporal and abusive punishment in Ohio schools except for situations of disarming a student, breaking up fighting among students, self-protection of teachers, or protection of students or another teacher. **House Bill 401,** sponsored by State Representative Judy Sheerer is currently in a subcommittee of the Ohio House of Representatives' Education Committee. State Senator Schafrath's legislation, **Senate Bill 179,** has been undergoing hearings in the Ohio Senate Education Committee.

Senate Bill 239, also sponsored by State Senator Richard Schafrath, would require all health insurance policies to cover adopted children on the same basis as other dependents. Senate Bill 239 has been referred to the Ohio Senate Financial Institutions and Insurance Committee.

Passage of the major CON program continuation bill meant that another bill abolishing the CON program, **House Bill 338** sponsored by State Representative Mike Fox of Hamilton, didn't pass. Two minor changes in CON law were made, passing as separate legislation. One is **House Bill 301** sponsored by State Representative Pat Sweeney (D-Cleveland) to revise the criteria for granting a CON for long-term facilities treating persons with Alzheimer's disease. It becomes effective on September 28, 1987. The other is **Senate Bill 98,** offered by State Senator David Hobson, to permit members of the CON need review board to serve two terms rather than be limited to one term. The bill became effective on June 30, 1987.

Children's Issues

A number of bills have been introduced in the 117th Ohio General Assembly concerning children. Probably the most controversial among those bills is House Bill 63, sponsored by State Representative Paul Jones (D-Ravenna), which would eliminate the exemption for spiritual treatment through prayer from the current child neglect and endangering statutes. The bill was considered and recommended for passage by the Ohio House Health and Retirement Committee. Prior to the committee's action, an unsuccessful attempt to weaken the bill through amendments was made by opponents to the measure. The major opponents were Christian Scientists.

House Bill 63, as introduced, would not disallow the use of spiritual treatment, nor would it eliminate the parents' role in determining treatment for their children in most routine circumstances. The bill would simply extend to those children being treated spiritually, who are in a life or health-threatening situation, the same statutory protection now granted the majority of Ohio's children. House Bill 63 would establish the means for the provision of appropriate life-saving care for those ill children who, without treatment, may not live, yet are unable to make that decision on their own. Again, this bill only extends to that group of children the same measure of protection under which the majority of Ohio's parents and children live today. The OSMA supports House Bill 63 and commends Representative Jones for its introduction. House Bill 63 is now in the Ohio House of Representatives' Rules Committee awaiting assignment to the Ohio House calendar for a floor vote.

House Bill 230, sponsored by State Representative E.J. Thomas (R-Columbus), would require every place where alcoholic beverages are sold to display on the premises a card stating "Warning: Drinking Alcoholic Beverages During Pregnancy Can Cause Birth Defects." House Bill 230 has been referred to the Ohio House of Representatives' Health and Retirement Committee.

Health Insurance

While there were a number of bills introduced in the area of health insurance, several pieces of legislation dominated the political action.

The highly controversial "selective contracting" bill, **Senate Bill 124,** sponsored by State Senator Roy Ray (R-Akron) and State Representative Ike Thompson (D-Cleveland), alters the manner in which hospital service associations (Blue Cross plans) do business in Ohio as newly-formed mutual insurance companies. The bill will grant Blue Cross the right to negotiate and contract with individual hospitals rather than be required to grant a contract to all hospitals in a given service area. The legislation provides for a phasing-in of the contracting program and establishes consumer protection in a number of areas that formerly existed in the hospital service association statutes repealed by this bill. Senate Bill 124 becomes effective on October 1, 1987.

House Bill 46, sponsored by State Representative Marc Guthrie (D-Newark), has passed the Ohio House of Representatives and will now be referred to the Ohio Senate for consideration. House Bill 46 would establish the **Ohio Comprehensive Health Insurance Plan** which would make health insurance coverage available to individuals in Ohio who are otherwise considered uninsurable. The Ohio Comprehensive Health Insurance Plan would be under the supervision of a 13-member board

of governors appointed by the superintendent of insurance and a medical physician would be appointed to the Board. Funding for the plan would be from the General Revenue Fund and premiums, and health insurers would be assessed $50 each to provide for start-up costs and initial reserves for the operation of the plan.

House Bill 46 would provide that the premiums for plan coverage would be 120% of the standard risk rate until May 31, 1989 and then could not exceed 175% of the standard risk rates established. The plan coverage would have a lifetime limit of $500,000 per person, subject to deductibles and co-insurance payments.

Prior to being voted out of the Ohio House of Representatives' Insurance Committee, a provision was added providing that an unfair and deceptive act or practice in the insurance business includes using unfair underwriting standards that are intended solely to render applicants, subscribers, or policyholders uninsurable in the normal health insurance market and to induce them to seek coverage in the Ohio Comprehensive Health Insurance Plan or other secondary health insurance mechanism.

State Senator Charles Horn (R-Dayton) introduced **Senate Bill 169** mandating that health insurance companies, health maintenance organizations, preferred provider organizations, and others obligated to pay health benefits pay providers within twenty-seven (27) days of receipt of a completed claim. Senate Bill 169 passed the Senate Financial Institutions and Insurance Committee and was sent to the Senate Rules Committee where, if approved, it would be voted upon by the full Senate.

House Bill 36, sponsored by State Representative Mike Stinziano (D-Columbus), would establish the Ohio Life and Health Insurance Guaranty Association. The bill would authorize the OLHIG Association to assess health insurers to cover the costs of paying benefits for insured individuals who hold policies with financially troubled health or life insurance companies. House Bill 36 was referred to the Ohio House of Representatives' Insurance Committee where it will be heard this summer and fall.

Also in the hearing process before the House Insurance Committee is **House Bill 543,** the Health Maintenance Organization bill. House Bill 543, sponsored by State Representative Mike Stinziano of Columbus would clarify which services are considered HMO basic health care services, would establish requirements for a service area expansion, would set a minimum amount of capital surplus to be met in order to be issued a certificate of authority, and would establish minimum net worth requirements and prescribe standards for reporting of net worth.

Senate Joint Resolution 8, which was adopted by the Ohio General Assembly, created a **Task Force on Mental Health, Alcoholism, and Chemical Dependency Treatment Financing.** This Task Force has been reviewing the existing private methods of financing treatment services and will be making recommendations to the Governor and the General Assembly for improvements in the state laws regulating such financing methods. The Task Force is to issue an interim report by October 31, 1987 and a final report by December 31, 1987.

State Representative E.J. Thomas of Columbus has introduced **House Bill 570** which would exclude a maximum of $2,000 of a taxpayer's catastrophic health insurance premiums from consideration in a person's adjusted gross income. This bill has been referred to the Ohio House of Representatives' Ways and Means Committee. Also introduced by State Representative Thomas is **House Bill 558,** which would authorize banks, savings and loan associations, life and health insurance companies, and sickness and accident insurance companies to establish trusts for individual medical accounts and exempt the interest on such accounts from the state income tax. This bill has been referred to the Ohio House of Representatives' Insurance Committee.

Tobacco and Smoking

A half-dozen bills regulating tobacco products and smoking have been introduced in the Ohio General Assembly. State Senator Charles Horn (R-Dayton) has authorized two: **Senate Bill 51** would permit municipalities, townships, and counties to regulate smoking in a more restrictive manner than state law; and **Senate Resolution 154** declaring the 117th Ohio General Assembly's support for a tobacco-free young Ohio by the year 2,000. Senate Bill 51 has passed the Ohio Senate and was referred to the House Commerce and Labor Committee. Senate Resolution 154 was adopted by the Ohio Senate on May 6, 1987. State Representative Ike Thompson (D-Cleveland) has introduced three tobacco measures. **House Bill 340** would prohibit distribution of free tobacco products and ban certain cigarette advertising. **House Bill 341** would restrict smoking in public places and **House Bill 456** would increase the state cigarette tax and dedicate a portion of the cigarette tax to fund cancer research. House Bills 340 and 341 have been referred to the House Commerce and Labor Committee. **Senate Bill 193** sponsored by State Senator Dick Schafrath (R-Loudonville) would change the law

by requiring smoking areas be designated rather than indicating no-smoking areas as is now done. This bill has been referred to the Senate Health, Human Services and Aging Committee.

"Living Will" Legislation

The concept of a "living will" has been before the Ohio General Assembly, in some legislative form for almost 10 years. The most recent proposal, **Senate Bill 148,** was introduced in the Ohio Senate by State Senator Robert Nettle of Barberton. Senate Bill 148 is very similar to the bill reviewed during the 1985-1986 session of the Ohio General Assembly. The current bill proposes requirements for the making and implementing of a "declaration of intent for a terminal patient" in Ohio. The legislation establishes immunity to physicians who comply with the "declaration" and the statutory requirements under which such "declaration" would be valid. Yet another section of the bill sets specific guidelines to be followed in situations where no "declaration" exists, but life sustaining treatment could be withheld. To date, no hearings have been held on Senate Bill 148.

Other Tort Reform

Related to medical liability reform, **House Bill 347,** sponsored by State Representative Mike Stinziano (D-Columbus) would create the Ohio Patient Compensation Fund (PCF) for the purpose of making available higher limits of medical liability insurance to licensed physicians. The bill would convert the assets and liabilities of the Ohio Joint Underwriting Association and the Stabilization Reserve Fund into the PCF. The PCF would cover only physicians who carry primary medical liability insurance, and it would provide excess insurance coverage for amounts in excess of $1 million but not more than $3 million. Physicians would be required to pay an annual assessment to the PCF. For those physicians who neither perform surgery nor administer anesthesia, the annual charge would be $250, while all other physicians would pay $750 annually. House Bill 347 has received several hearings before the House Insurance Committee.

Senate Bill 142, sponsored by State Senator M. Ben Gaeth of Defiance, has passed the Ohio Senate and has been referred to the Ohio House of Representatives' Civil and Commercial Law Committee. Senate Bill 142 would provide immunity from civil liability to a physician who in good faith signs an affidavit stating a person has a physical impairment that makes use of an occupant restraining device impossible or impractical.

Other Legislation

HOUSE BILL 12 (Hinig, D-New Philadelphia) — Creates a new temporary handicapped parking card for persons disabled less than 12 months, in addition to permanent handicapped parking cards. Effective: September 10, 1987.

HOUSE BILL 56 (P. Jones, D-Ravenna) — Would require Ohio medical schools to incorporate a program on developmental disabilities into medical education, authorizes granting of fellowships in caring for persons with developmental disabilities, and makes an appropriation to fund program. Passed Ohio House of Representatives' Health and Retirement Committee and referred to Ohio House of Representatives' Finance and Appropriations Committee.

HOUSE BILL 135 (Boehner, R-West Chester) — Would prohibit the use, possession, manufacture, sale, or advertising of drug paraphernalia. Referred to the Ohio House of Representatives' Judiciary and Criminal Justice Committee.

HOUSE BILL 190 (I. Thompson, D-Cleveland) — Mandatory Helmets for Motorcycle Operators and Passengers. Referred to the Ohio House of Representatives' Highways and Public Safety Committee.

HOUSE BILL 396 (P. Jones, D-Ravenna) — Reorganizes the Ohio Department of Mental Health. Referred to the Ohio House of Representatives' Health and Retirement Committee.

HOUSE BILL 520 (Schuck, R-Columbus) — Would prohibit prescription or sale of anabolic steroids to minors for purpose of enhancing athletic performance. Referred to the Ohio House of Representatives' Health and Retirement Committee.

SENATE BILL 156 (Hobson, R-Springfield) — Reorganizes the Ohio Department of Mental Health. Referred to the Ohio Senate Health, Human Services and Aging Committee.

SENATE BILL 238 (R. Schafrath, R-Loudonville) — Requires the Bureau of Motor Vehicles to have available medical alert stickers when requested by an owner of a motor vehicle. Referred to the Ohio Senate Highways, Transportation and Local Government Committee.

The OSMA legislative staff extends a "thank you" to the Council of the OSMA, the Committee on Legislation, the OSMA Auxiliary, and all individual physicians and county societies who have taken the time to become actively involved in the OSMA legislative effort. The work of and the support from these individuals greatly assisted in resolving many of the issues impacting organized medicine. An active and informed OSMA membership is also important for the future of the OSMA legislative

program. The Department of Legislation staff encourages individual physicians, physician groups, medical staffs, county societies, specialty societies, and the auxiliary to contact the department regarding legislative issues and concerns. The staff is available upon request to present legislative updates and briefings. The continuance of an informed and involved physician community is essential for the continued success of the OSMA legislative effort. **OSMA**

The OSMA Department of Legislation staff: Rick Ayish, Director of Legislation; John E. Van Doorn, Director of State Legislation; and Associate Directors Kent Studebaker and Carolyn Towner.

The medical professional liability reform bill . . . *continued*

necessary. The committee will report its findings to the General Assembly no later than January 15, 1989.

These provisions should assist in stabilizing the medical liability insurance market. Other provisions, such as collateral source, joint and several liability, punitive damages, and contingency fees were not part of the bill as passed, but either are being improved for medical liability claims in House Bill 1, the general tort reform bill, or are at best unaltered from current law.

Due to the continued opposition to many provisions in House Bill 1 by the trial attorneys, organized labor and the Ohio Public Interest Campaign, no consensus was achieved on the bill prior to adjournment. A joint House-Senate conference committee was named in an attempt to resolve the differences between the two houses. Indications are that if such an agreement can be reached, the legislature may be brought into a special session to act on the measure. Governor Celeste vetoed a similar bill last session. To date, there is no indication that the Governor will sign House Bill 1, even when approved by the legislature. — *The OSMA Department of Legislation*

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As of July 24, 1987, over 2,230 donations to OSMA's Professional Liability Legislative Action Fund have been received from those individuals and groups who are listed below.

The fund was established by the OSMA Council in March 1987, to support activities related to the enactment of tort reform legislation, specifically House Bill 327, through which the OSMA sought reforms to stabilize the medical liability insurance marketplace.

To date, $151,183 has been raised. The fund will continue to allow the OSMA to follow legislation in this area, and to participate in any court cases that may affect the professional liability environment. The fund is also being used to educate legislators, physicians, patients and the public about the professional liability issue; for legal and statistical assistance; for the ongoing activity of OSMA's Task Force on Professional Liability; and, since the adopted bill provides for a professional liability study commission, the fund may also be used to support any action called for by this commission. Any legislative action fund money not spent on these activities will be saved for future needs — as long as those needs relate directly to the professional liability issue. Each dollar spent from the fund, in fact, is used specifically to help solve the professional liability crisis, and is not used in any way to assist the OSMA in its operating costs.

Because the work in this area is ongoing, contributions may still be made by sending your check to: The Professional Liability Legislative Action Fund, the Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

And thanks to all of you who have already contributed . . .

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continued on page 608

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Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics, therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982 5685

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2. Beaver, WT *Arch Intern Med*, 141: 293-300, 1981



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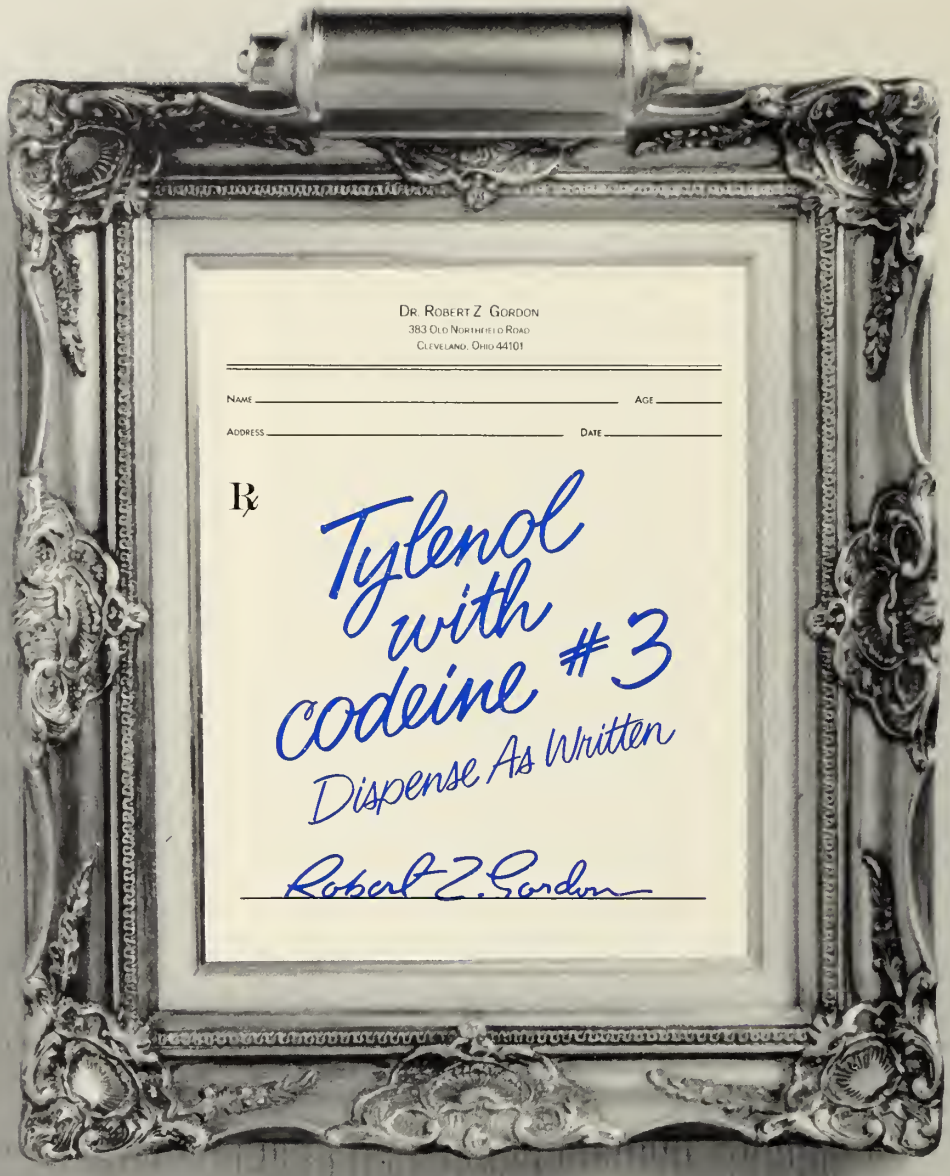
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President's Page . . . *continued*

a dollar spent at home, in your local area, carries much more weight than a contact made at the state level. That's why it is so important for *you* to get involved.

In addition to the personal contact and participation in local fund-raisers, wholehearted support of OMPAC would produce the most significant results. Currently, only 15% of the OSMA membership participates in OMPAC. Think of what we could do if that figure were raised to 100%!

As physicians, we are faced with a situation in which we must look to ourselves rather than to others for a solution to the problem. If all Ohio physicians were members of OSMA, and if all Ohio physicians supported OMPAC, the logical conclusion must be that we are taking charge and making the *right* change . . . for a change. **OSMA**

D. Ross Irons, MD, is President of the OSMA.

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Minutes of the OSMA/MSS Annual Meeting

Embassy Suites Hotel,
Columbus, Ohio
February 28, 1987

I. Meeting was called to order by Brian Jewell (MCO), president, at 9:05 am. In attendance were:

CWRU: Peter Eckel, Peter Spiegel, Adrienne Knight

MCO: Naakesh A. Dewan, Karen Guss, Joel Gelman, Brian Jewell, Richard Steinman, Lynne Sheffler, Chris Reese

OSU: Mike Aruta, Henry Schneider, Don Sullivan, Mary Riess, Mick Dick, Cathy Yeagley

UC: Richard Bahner, Steve Gilreath, John Hughes, Tim Beer, Jack Shohet, Karen Fried, Marcia Reeder, Tom Broderick

NEOUCOM: Liza Anderson, Carol Marquinez, Stacey Hollaway

WSU: Peter Spatt, Derrick Jeter, Ron Zile, Ron Golovan, Jeff Kittle, Crystal Higden, Denise Reeves

OSMA: David Torrens, Carol Maddy

II. The minutes of the 1986 Annual Meeting were approved as written.

III. Brian Jewell gave the Assembly his State of the Section address, commenting on his past motivations to enter medicine, reminding us how medicine is a profession (and defining his meaning of "profession,") and the most important factors, as he saw it, affecting medicine today. He further enunciated some of the progress of the MSS this past year, including

a) our obtaining an alternate delegate on Ohio's AMA delegation
b) attendance at AMA-MSS Annual Meeting in Chicago, where 22 students from Ohio attended
c) student membership in Ohio as approximately 90%
d) impact of OSMA Councilor lecture series
e) progress made by N. Dewan and R. Steinman of MCO in their Student-to-Student community outreach program.
f) outstanding student participation at NEOUCOM.

He further identified the following areas needing improvement:

a) improve communications between delegates and students back home
b) improve local chapter structure
c) improve student participation at CWRU.

Address by Dr. Oscar W. Clarke

IV. The assembly was addressed by Oscar W. Clarke, MD, chairman of Ohio's delegation to the AMA. After congratulating Brian on his year in office, Dr. Clarke informed the MSS Assembly that Ohio's delegation to the AMA now consists of 18 delegates and 18 alternate delegates. Other highlights from Dr. Clarke's presentation included the following:

a) support for students is very strong in the OSMA;
b) Dr. Clarke informed the school delegations of his work on the AMA Medical-Legal Committee and some of the ethical dilemmas discussed by the committee with respect to drug testing and AIDS;
c) Aspects of AMA-sponsored tort reform nationally, and tort reform in the State of Ohio;
d) Payment mechanisms for doctors.

V. **Reports**

A. AMA/MSS Report: Cathy Yeagley (OSU), vice president

Cathy explained to the assembly the function of the MSS and the times of the year that the AMA/MSS Assembly met for business. She reviewed for the assembly the various resolutions enacted by the AMA/MSS assemblies at the A-86 and I-86 meetings. Of particular interest to students at the A-86 meeting were resolutions on: smoking in hospitals, medical school education, medical ethics, medical economics, computers in medicine and the AMA/MSS public service project (Hunger in America). Other resolutions of interest were: childhood vaccines, medical

student exchange with foreign nations, and the proposed physician draft.

Important resolutions at the I-86 meeting included: student loans, pound animals in research, physician media advertising, medical student stock in tobacco companies, hepatitis B vaccine, and various internal issues involving the AMA/MSS Governing Council. Cathy congratulated the assembly for the excellent level of participation and preparation of all who attended and recognized those students from Ohio who served on various committees on the national level. She also thanked David Torrens for his help and assistance during the past year.

B. AMA-Alternate Delegate Report

Joel Gelman, the OSMA/MSS Alternate Delegate to the AMA, presented a written and verbal report to the assembly. Joel detailed the history of the creation of his position, as well as Ohio's support for student concerns. He further explained the role of the student alternate delegate to the function of the delegation. Joel's report was approved and accepted for filing.

C. OSMA Membership Committee Report

Derrick Jeter, the OSMA/MSS representative to the OSMA Membership Committee, provided both a written report and oral testimony concerning the activities of the Membership Committee. He explained for the assembly the purpose of the committee and highlighted the following concerning student membership:

1) University of Cincinnati — 125 of 148 students recruited
2) Ohio State University — 225 of 233 students recruited
3) Medical College of Ohio — 134 of 147 students recruited
4) Wright State University — 86 of 90 students recruited
5) NEOUCOM — 49 of 102 students recruited
6) Case Western Reserve — 48 of 139 students recruited

Total student membership is approximately 78% of full capacity. Four schools received outreach awards and placed in the top 12 schools in the country in recruiting.

Future goals include increasing student membership in the OSMA to 90%. All the benefits of OSMA/AMA membership should be used in student recruitment efforts. Direct mailings could be used where practicable.

Physician membership has increased from 10,999 in 1985 to 11,099 in 1986. A new membership category for married physicians has been recommended to OSMA Council (1.5 times regular membership fee). Derrick was thanked for the completion of his report, and it was approved and accepted for filing.

D. OSMA Communications Committee Report

Nick Dewan presented the assembly with a verbal presentation of his written report concerning his activities with the Communications Committee this past year. Nick informed the assembly of efforts on the part of the committee to educate the public on changes in health care through publication of 120,000 copies of the booklet, "Changes in Health Care." Over 900 copies of the Professional Liability kits were also distributed.

Other decisions of the Communications Committee included:

a) more effort to be made into area of internal communication projects;
b) approval of a concept of a handbook for officers of county medical societies to include #'s of OSMA staff, OSMA programs and speakers, and a list of current OSMA resolutions;
c) production of a special monthly report to county medical society presidents;
d) investigating possibility of establishing a display case at selected hospitals containing information about OSMA;
e) purchase of an anti-smoking TV ad;
f) changing name of *Synergy;*
g) changing name of *OSMA Journal* to *OHIO Medicine;*
h) approval of MCO's Student-to-Student project.

Nick's report was approved and accepted for filing, and he was thanked for his participation on the committee.

E. OSMA/MSS Reports

1. Secretary's Report: Stephen Gilreath (UC), reported in general on the proceedings of the governing council meetings held this past year. He encouraged greater student participation in these meetings. He also directed the assembly's attention to the calendar of upcoming events under tab 9 of the agenda book and pointed out those special events coming up in the near future.

He reminded the representatives of their responsibility to educate their student constituencies at home on the substance of the Annual Meeting and pledged better results in getting copies of all minutes to all representatives.

2. Ad-Hoc Committee on Bylaws Review: Cathy Yeagley (OSU) reviewed for the assembly the purpose of the committee and the nature of the charge it had. She informed the MSS of the legal counsel authorship of Resolution #1 for governing council, and recommended the dissolving of the committee for next year.

3. Student-to-Student Project: Richard Steinman (MCO) presented the assembly with the history of MCO's pilot project and

their affiliation/cooperation with the OSMA Department of Communications. He explained how brochures were distributed to schools with discussion topics including how the heart, lung and brain work, smoking, drug and alcohol abuse, how to become a doctor, and AIDS. Greater than 120 hours instruction has been requested so far. Members of every class from MCO have been recruited to participate. Nick Dewan (MCO) presented the assembly with a sample of the printed graphics used in these presentations.

VI. **Elections-Nominations & Speeches**

AMA Alternate Delegate:
Stephen Gilreath (UC)
Joel Gelman (MCO)
OSMA/MSS President:
Derrick D. Jeter (WSU)
OSMA/MSS Vice President:
Karen Guss (MCO)
OSMA/MSS Secretary:
Richard Steinman (MCO)

VII. **Presentation of Resolutions**

MSS 1-87. Voting Procedure for Election of OSMA/MSS Officers and an Alternate Delegate to the American Medical Association House of Delegates.
Action Taken: Passed as amended.
MSS 2-87. OSMA/MSS Bylaws
Action Taken:
Resolved 1: Passed.
Resolved 2: Passed.
Resolved 3-13: Passed.
Resolved 14: Passed as amended.
Resolved 15-16: Passed.
Resolved 17: Withdrawn.
Resolved 18: Passed as amended.
Resolved 19: Passed.
Resolved 20: Withdrawn.
Resolved 21-23: Passed.
MSS 3-87. Hazards of All-Terrain Vehicles
Action Taken: Passed as amended.
MSS 4-87. Civil Aeromedical Helicopter Industry Safety
Action Taken: Passed as amended.
MSS 5-87. Labelling of Generic Substitutions
Action Taken: Passed as amended.
MSS 6-87. Drug Product Tampering
Action Taken: Passed as amended.
MSS 7-87. Alcohol Impaired Driving
Action Taken: Withdrawn by author.
MSS 8-87. Medical Student Impairment Programs
Action Taken: Passed.
MSS 9-87. OSMA/MSS Sponsored Medical Student Research Contest
Action Taken: Passed as amended.
MSS 10-87. OSMA Policy on Advertising
Action Taken: Passed.
MSS 11-87. Student-to-Student Community Health Education Project
Action Taken: Passed as amended.
MSS 12-87. Teenage Pregnancy
Action Taken: Passed as amended.

VIII. **Address by Dr. Abromowitz and Dr. Helmsworth**

Dr. Abromowitz congratulated Brian for his year of presidency and Joel for his service as AMA Alternate Delegate. He further commented on the assembly's growth and maturity. He encouraged continued participation in organized medicine.

Dr. Helmsworth addressed the assembly on the creation of the new Resident Physicians Section. The RPS will have one delegate and one alternate delegate in the House of Delegates. Bylaws are expected to be approved in May. He encouraged student participation for those graduating and doing residencies in Ohio.

IX. **Other Reports**

A. National Leadership Conference: Brian Jewell (MCO) reported on this AMA-sponsored conference held 2/20-2/22 in Chicago, called "Taking Charge of Change." Six students attended from Ohio. He encouraged these students to share this information with their constituencies at home.

B. Local Chapter Structures: Brian reported that though governing council had been mandated by resolution to determine local chapter structures, that this had turned out to be a much larger task than anticipated. Chapter structures were so different, that only information on structure (and not recommendations for standardization) was able to be performed.

Elicited data is available from the secretary. This is a task to be completed by the new governing council.

X. **Election Results**

AMA Alternate Delegate:
Stephen W. Gilreath (UC)
President:
Derrick D. Jeter (WSU)
Vice President:
Karen Guss (MCO)
Secretary:
Richard Steinman (MCO)

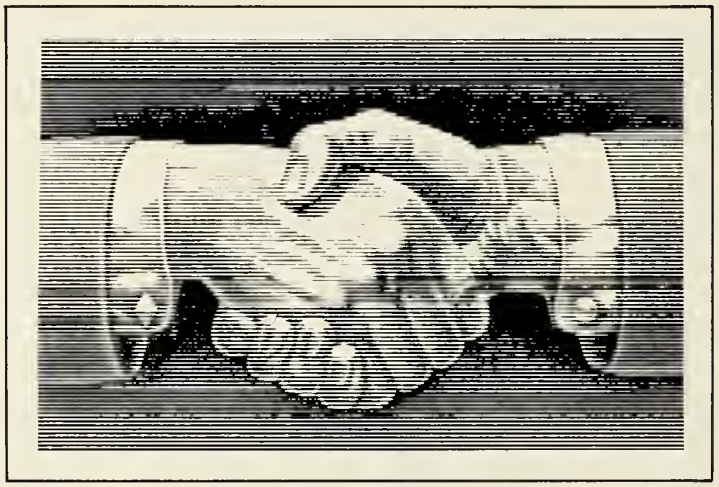
XI. **Delegates to 1987 OSMA Annual Meeting**

UC: Stephen W. Gilreath
MCO: Naakesh Dewan
CWRU: Peter Eckel
WSU: Peter Spatt
OSU: Mike Aruta
NEOUCOM: Stacey Holloway

XII. **Final Remarks & Adjournment**

Brian Jewell was thanked for his leadership during the past year. David Torrens was thanked by the governing council for his help. The 1987 OSMA/MSS Annual Meeting was adjourned by Derrick Jeter at 4:30 pm.

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Respectfully submitted,
Stephen W. Gilreath
1986-87 OSMA/MSS Secretary

DISPOSITION OF RESOLUTIONS ACTED UPON AT THE OSMA/MSS ANNUAL MEETING

Amended Resolution 1-87

RESOLVED, That Chapter VIII, Section 2 — Election of Officers and Chapter XV — AMA Alternate Delegate of the OSMA/MSS be amended so the election process of the Officers and AMA Alternate Delegate is definitive and specific; and be it further

RESOLVED, That the OSMA/MSS Bylaws, Chapter VIII, Section 2 ("Election of Officers"), shall be amended to provide as follows:

Section 2 — Election of Officers. Officers of the OSMA-MSS shall be elected by majority vote for one-year terms by nomination from the floor of the OSMA-MSS Annual Assembly. The election of officers of the OSMA-MSS shall be by ballot. The nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken; this procedure shall continue until there are two nominees remaining. The nominee receiving a majority of all votes cast shall be declared elected. Those elected shall assume office at the conclusion of the OSMA Annual Meeting. Any vacancy in any office shall be filled by an interim officer selected by the OSMA-MSS Governing Council until such vacancy can be filled by election at an OSMA-MSS Assembly.

RESOLVED, That the OSMA-MSS Bylaws Chapter XV ("AMA Alternate Delegate") shall be amended to provide as follows:

An alternate delegate to the American Medical Association House of Delegates shall be elected by the OSMA-MSS Annual Assembly for a one-year term. Nominations for the AMA Alternate Delegate shall be made by the OSMA-MSS Governing Council to the assembly and election shall be by ballot. The nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken; this procedure shall be continued until there are two nominees remaining. The nominee receiving a majority of all votes cast shall be declared elected. The alternate delegate elected shall assume office at the time of election and shall be eligible for re-election so long as a student status is maintained. Any vacancy shall be filled by an OSMA-MSS member selected by the OSMA-MSS Governing Council until such vacancy can be filled by election at an OSMA-MSS Assembly.

(Original Resolve Clauses: In Section 2, 2nd sentence: During the election process, the OSMA-MSS president will place a vote for each position in private to be counted only in the event of a tie. In the event three or more candidates are running the same office and a tie between two candidates for the most votes is tallied, then a runoff election between the top two candidates shall follow.

In Chapter XV "AMA Alternate Delegate," second sentence read: Nominations for the AMA Alternate Delegate shall be made by the OSMA/MSS Governing Council to the assembly and election shall be by majority vote of the assembly in accordance with the OSMA bylaws. During the election process, the OSMA-MSS president will place a vote in private to be counted only in the event of a tie. In the event of three (3) or more candidates are running and a tie between two (2) candidates for the most votes is tallied, then a runoff election between the top two candidates shall follow.)

MSS Assembly Action: Passed as amended.

Amended Resolution 2-87

RESOLVED, That the Bylaws be amended as follows:

Chapter III, paragraph 2

Any medical student of an Ohio college of medicine or osteopathy may seek membership in the OSMA-MSS, attend meetings of the OSMA-MSS Assembly (as described in Chapter V) as an observer, and speak to issues before the OSMA-MSS Assembly.

Chapter V, add the following sentences

A quorum of the assembly shall be defined as 50% plus one of the total assembly membership. A quorum is required for any action of the assembly.

Chapter VI, second sentence

In addition, each chapter shall select no more than three alternates to serve in the event of absence of one or more of its representatives.

Chapter VI, fourth sentence

Representatives shall serve for a

one-year term and shall be selected prior to the OSMA-MSS Annual Assembly.

Chapter VII

The Governing Council of the OSMA-MSS shall consist of the officers and the delegates. The immediate past president shall serve as an ex-officio member of the council. A quorum of the governing council shall be defined as 50% plus one of the governing council membership. A quorum is required for any action of the governing council.

Chapter VIII Section 3, 1.

a) The president shall preside over all meetings of the OSMA-MSS Assembly and the OSMA-MSS Governing Council.

Chapter VIII Section 3, 1., add e) and f)

e) The president shall serve as the chairperson of the OSMA-MSS delegation to the AMA-MSS Annual and Interim meetings and the OSMA Annual Meeting, and as such shall initiate and preside over all meetings of the delegation.

f) The president shall regularly communicate with other members of the governing council regarding business and activities of the OSMA-MSS.

Chapter VIII Section 3, 2., add e)

e) The vice-president shall be responsible for reporting to the OSMA-MSS Assembly on the proceedings of the AMA-MSS Annual and Interim meetings.

Chapter VIII Section 3 3., change c.

The secretary shall certify that a quorum is present before any official action is taken by the assembly or governing council.

Chapter IX should read

Any officer can be recalled by unanimous vote of all members of the OSMA-MSS Governing Council. The officer subject to recall shall be notified in writing of the charges against him/her at least 10 days in advance of the recall vote and be given the chance to speak before the OSMA-MSS Governing Council on his/her behalf. Vacancies shall be filled as provided in Chapter VIII, Section 2.

Chapter X, change title

OSMA-MSS Delegates

Chapter X Section 2, delete Item 2 — change 3 to 2 and 4 to 3

Section 1 — Delegates Selection. From each local chapter's group of representatives, two students shall be selected: one to serve as delegate and the other as alternate delegate to the OSMA-MSS Governing Council. These delegates shall also serve as delegates to the OSMA House of Delegates as provided in the OSMA Constitution, Article IV, Subsection (3).

Section 2 — Delegate's Responsibilities.

1. Attendance to all OSMA-MSS Governing Council meetings.

2. Attendance to the OSMA District caucuses of each delegate's respective medical school area district.

3. Research of designated resolutions prior to their presentation at the OSMA Annual Meeting.

Chapter X Section 3, change to

Section 3 — Replacing School Delegates. If in fact a delegate does not meet the above responsibilities listed in Section 2, and a unanimous vote of the other governing council members is obtained, the governing council shall by letter to the delegate document the specific failures of the delegate in meeting his/her specified responsibilities and state that he/she is being considered for replacement by a new delegate who will represent the school. The delegate shall have the opportunity to defend his/her performance at the OSMA-MSS Governing Council meeting before a vote of governing council members is taken.

Chapter XI, Council Functions, should read

1. The governing council shall hold meetings to conduct business and to prepare resolutions throughout the year. The council may schedule meetings in whatever manner it sees fit.

2. The governing council shall make every attempt to ensure the selection of delegates from participating medical schools.

3. The governing council shall be responsible for the dismissal of committee members and the dissolution of committees by a majority vote of governing council members present. In addition, governing council may dismiss OSMA-MSS delegates (Chapter X Section 3), AMA-MSS Delegates (Chapter XIV), OSMA-MSS officers (Chapter IX).

4. The council shall be responsible for a general review of the bylaws of this organization every two years which shall include recommendations for additions and exclusions aimed at aligning the bylaws with the current objectives and structure of the organization.

Chapter XII first sentence should read

The OSMA-MSS shall hold its Annual Assembly prior to the annual House of Delegates meeting of the OSMA.

Chapter XII Section 1 — Business At Its Meetings, first sentence should read

The OSMA-MSS shall address resolutions to be submitted to the

OSMA House of Delegates and to the AMA-MSS; receive reports from its officers, delegates, representatives and others as designated; and conduct any other appropriate business.

Chapter XIII Paragraph 2 should read

Resolutions that are AMA policy proposals shall require a majority vote of the OSMA-MSS Assembly before being submitted to the OSMA, AMA-MSS House of Delegates in the name of the OSMA-MSS.

Chapter XIV Paragraph 1 should read

Each local chapter shall select one delegate and one alternate delegate to serve at the AMA Medical Student Section. Each chapter shall forward the names of said delegates to the secretary of the OSMA-MSS. The AMA-MSS delegates and alternates shall be subject to recall in the same manner as the OSMA-MSS delegates as in Chapter X Section 3.

Chapter XVI should read

These bylaws may be amended by the OSMA-MSS at any of its meetings provided that the amendment shall have been proposed not less than thirty (30) days prior to the OSMA-MSS Assembly and that two-thirds of the voting members concur with the amendment. Any such amendments are subject to approval by the OSMA Council at its next regularly scheduled meeting.

(Original Resolve Clauses: The amendment to Chapter XI 3. was changed by deleting the words "and AMA Alternate Delegate (Chapter XVI) at the end of the second sentence. **passed as amended**

The amendment to Chapter XIII Paragraph 2. was changed by deleting the words "or AMA" at the end of the second paragraph, after the words OSMA, AMA-MSS . . . **passed as amended**

Chapter XII Section 2 . . . except as superceded by these bylaws. **withdrawn**

Chapter XVI (new Chapter) The AMA Alternate Delegate shall be subject to recall under the same procedure as the OSMA-MSS officers as provided for in Chapter IX. **withdrawn)**

MSS Assembly Action: Passed as amended

Amended Resolution 3-87

RESOLVED, That the OSMA-MSS ask the AMA-MSS to encourage the AMA to lobby the U.S. Consumer Product Safety Commission for engineering changes in the design of ATVs to enhance rider safety; and, be it further

RESOLVED, That the OSMA encourage all physicians to determine ATV usage among their patients, educating them in the interest of improving the public health.

(Original Resolves:

RESOLVED, That the AMA-MSS encourage the AMA to support the following:

1. a minimum driving age in each state equivalent to that for a motorcycle operator's license for all individuals desiring to operate an ATV.
2. that appropriate driver training be required and that individuals be licensed in like manner as automobile drivers.
3. that ATV operators be registered and insured drivers and subject to all laws otherwise governing safe motor vehicle operation in their state of residence.
4. that each state:
   a) prohibit operation of ATVs on public roads or hazardous terrain (with those exceptions as provided by each state legislature), or anywhere after dark,
   b) require the use of helmets and other protective clothing for all ATV operators,
   c) restrict the number of passengers riding on each vehicle;

and, be it further

RESOLVED, That the AMA-MSS encourage the AMA to lobby the U.S. Consumer Product Safety Commission for engineering changes in the design of ATVs to enhance rider safety; and, be it further

RESOLVED, That the AMA encourage all physicians to determine ATV usage among their patients, educating them and promoting those recommendations above in the interest of improving the public health.)

MSS Assembly Action: Passed as amended.

Amended Resolution 4-87

RESOLVED, That the Ohio State Medical Association determine through careful study and research:

1) the identity of all civil aeromedical helicopter programs in the State of Ohio along with their accident rate.
2) the factor(s) necessitating the implementation of each program, as well as the reasons for continued existence from each program administrator; the number of pilots participating in each program; program funding; the number of aeromedical helicopter programs per city; and any other factors deemed necessary in presenting an objective picture of the

status of the aeromedical helicopter industry in the state of Ohio; and, be it further

RESOLVED, The OSMA publish these results for the aeromedical helicopter industry in Ohio in *OHIO Medicine* along with any other safety recommendations not contained in the report of the safety committee of the American Society of Hospital Based Emergency Aeromedical Services, by December 1, 1987.

(Original Resolve Clauses: In the first Resolved, 2), after program funding; the original resolution read — "advantages of air transport over ground transport in each instance";

In the second Resolved, the original resolution read "in the *Ohio State Medical Journal* along with"

The third Resolved was deleted and in the original resolution read as follows:

RESOLVED, that the OSMA encourage the AMA by resolution (in time for the 1-87 meeting) to pursue through appropriate legislation, placing the civil aeromedical helicopter industry under strict FAA control with the appropriate modifications made for the medical helicopter industry.)

MSS Assembly Action: Passed as amended.

OSMA House Action: OSMA Resolution No. 53-87 was referred to the OSMA Council.

Amended Resolution 5-87

RESOLVED, That the OSMA-MSS ask the OSMA to draft a letter expressing the concerns relative to proper generic drug dispensing and labelling and to distribute this letter to the president of the Ohio State Pharmaceutical Association, the State Board of Pharmacy and other such leaders of the profession of pharmacy as the OSMA sees fit.

(Original Resolves: [The following Resolves were deleted in the final resolution and were the first 2 Resolves in the original resolution]

RESOLVED, That the Ohio State Medical Association Medical Student Section urge pharmacists to indicate on the container of all medication in which the pharmacist has made a generic substitution (1) the generic name of the medication dispensed, (2) the distributor of the medication dispensed, and (3) the statement "Generic Substitution Made."

RESOLVED, That the OSMA-MSS publicize to the public and medical students that Section 4729.38 paragraphs (D) and (E) of the Ohio Revised Code as they now read:

(D) No pharmacist shall dispense a generically equivalent drug under this section and charge more than the regular and customary retail price for that drug.
A pharmacist shall indicate on the container or its label the notation "Generic Substitution Made" when dispensing at retail a generically equivalent drug for the brand name drug prescribed. This requirement shall be in addition to all other labeling requirements of Chapter 3715. of the Revised Code.

(E) If the drug dispensed has no brand name, a pharmacist shall include the generic name and distributor of the finished dosage form on the prescription.)

MSS Assembly Action: Passed as amended.

OSMA House Action: OSMA Resolution No. 48-87 was adopted.

Amended Resolution 6-87

RESOLVED, That the Ohio State Medical Association Medical Student Section Governing Council investigate and report by the 1988 Annual Meeting, the ideals of the Michigan Pharmacists Association program known as "Pharmacist Choice," namely:

(1) the product has never been offered for sale on a self-serve basis;
(2) the product has not been resold; and
(3) all personnel in the pharmacy have been properly advised and instructed.

(Original Resolved: The first sentence in the original resolution read as follows:

RESOLVED, That the Ohio State Medical Association Medical Student Section supports the ideals of the Michigan Pharmacists Association program known as Pharmacist Choice namely:)

MSS Assembly Action: Passed as amended.

Resolution 7-87

This resolution was withdrawn by the author.

Resolution 8-87

RESOLVED, That the OSMA-MSS conduct a survey of existing impairment programs for medical students at Ohio medical schools; and be it further

RESOLVED, That the OSMA-MSS make the results of this survey available to Ohio medical students in an acceptable manner before the next annual OSMA-MSS meeting; and be it further

RESOLVED, That the OSMA-

MSS work in conjunction with any Ohio medical school wishing to incorporate ideas from the AMA-MSS publication "A Primer on Medical Student Impairment" into their student impairment programs.
MSS Assembly Action: Passed.

Amended Resolution 9-87

RESOLVED, That the OSMA-MSS ask the editor (or editorial review board) of *OHIO Medicine* to solicit, from Ohio medical students doing original, student initiated research, short papers which summarize their research efforts and results; and be it further

RESOLVED, That the above committee may select one or more (up to 3 maximum) of the best papers, at their discretion, for publication in *OHIO Medicine;* and be it further

RESOLVED, That the editor (or board) consider this as an annual event.

Original Resolution read as follows:

RESOLVED, That the OSMA-MSS initiate a committee consisting of no more than one student from any one medical school to solicit, from Ohio medical students doing research, short papers which summarize their research efforts and results; and be it further

RESOLVED, That the above committee select one or more of the best papers, at their discretion, for submission to the OSMA for their consideration for publication in *OHIO Medicine;* and be it further

RESOLVED, That the above committee submit their recommendation to the next OSMA-MSS Annual Meeting whether this should be an annual contest.)

MSS Assembly Action: Passed as amended.

Resolution 10-87

RESOLVED, That the OSMA approve of and support public relations/service announcements which enhance the public's ability to make informed decisions regarding health care; and

RESOLVED, That the OSMA encourage its members to follow advertising practices:

1. which are not false, fraudulent, deceptive or misleading; and
2. which are designed to give the public adequate information regarding the nature and scope of the various medical specialties to permit individuals to make informed choices regarding their selection of physicians.

MSS Assembly Action: Passed.

OSMA House Action: OSMA Resolution No. 56-87 was made Substitute Resolution No. 35-87 and was adopted by the OSMA House. Substitute Resolution No. 35-87 reads as follows:

RESOLVED, That the Ohio State Medical Association recognize the increasing use of public relations/service announcements which purport to enhance the public's ability to make informed decisions regarding health care; and, be it further

RESOLVED, That the OSMA encourage its members who wish to market their services to adopt marketing practices:

1. which are not false, fraudulent, deceptive or misleading; and
2. which are designed to give the public adequate information regarding the nature and scope of the various medical specialties to permit individuals to make informed choices regarding their selection of physicians; and, be it further

RESOLVED, That the Ohio State Medical Association examine the issue of hospital advertising.

Amended Resolution 11-87

RESOLVED, That the OSMA-MSS ask the OSMA to support the concept of the Student-to-Student health education project and provide support for publishing this OSMA-MSS project.

(Original Resolution read:

RESOLVED, That the OSMA make every effort to publicize the Student-to-Student Community Health Education Project, to all Ohio physicians, medical students, and health professionals; both OSMA members and non-members; and be it further

RESOLVED, That the OSMA support the creation of "sister projects" in other states, through support and presentation of resolutions to the AMA at the A87 National meeting.)

MSS Assembly Action: Passed as amended.

OSMA House Action: OSMA Resolution No. 57-87 was amended as follows, then adopted.

RESOLVED, That the Ohio State Medical Association support the concept of the Student-to-Student Health Education Project at all Ohio medical schools and provide financial support for printing and mailing costs of brochures and project handbooks for this OSMA-MSS project.

Amended Resolution 12-87

RESOLVED, That the OSMA-MSS request the AMA-MSS to investigate the effects of school-based birth control and school-based health/birth control clinics to determine if results of such clinics are desirable, and then to formulate a report on such clinics based on said investigation.

continued on page 647

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Report of the Annual Business Meeting of the American Medical Association

June 21-25, 1987

By Oscar W. Clarke, MD, Chairman
Ohio Delegation to the AMA
and
D. Ross Irons, MD, Co-Chairman
Ohio Delegation to the AMA

This report covers some of the important issues voted on by the Ohio Delegation at the 1987 Annual Business Meeting of the American Medical Association in Chicago, Illinois, June 21-25, 1987.

There were 81 reports and 195 resolutions considered by the House of Delegates. The following report contains four resolutions which were submitted by the Ohio Delegation to the AMA.

Oppose Physician DRGs

The American Medical Association House of Delegates adopted the following substitute resolution in lieu of four resolutions, including one from Ohio, on the subject of physician DRGs:

"**RESOLVED,** That the American Medical Association continue its vigorous opposition to any proposal that would reimburse physicians according to diagnosis related groups (DRGs); and be it further

RESOLVED, That the American Medical Association continue its opposition to the discriminatory proposal by the U.S. Office of Management and Budget to include compensation of radiologists, anesthesiologists, and pathologists under in-hospital diagnosis related groups (DRGs); and be it further

RESOLVED, That the AMA continue to encourage members of the Congress of the United States to support concurrent Resolution H. 30 and S. 15, opposing the inclusion of physicians in any DRG program; and be it further

RESOLVED, That the AMA through its physician members seek support of patients in opposing the inclusion of physicians in the DRG reimbursement plans."

Standardized Insurance Forms

The AMA House of Delegates adopted the following resolution submitted by the Ohio Delegation:

"**RESOLVED,** That the American Medical Association work with the various federal, state, local and commercial third party carriers to establish a uniform reporting system for forms and codes for medical care in the United States."

Drug Paraphernalia

The AMA House of Delegates adopted the following substitute resolution in lieu of a resolution submitted by the Ohio Delegation:

"**RESOLVED,** That the AMA reaffirm existing policy, as stated in Board of Trustees Report N (A-82), to oppose the manufacture, sale and use of illicit drug paraphernalia, and that the

Association continue to support legislation to implement this policy."

AIDS Public Awareness and Information Program

The AMA House of Delegates adopted the following amended substitute resolution in lieu of seven resolutions, including one from the Ohio Delegation, on the subject of AIDS public awareness:

"**RESOLVED,** That the American Medical Association:

(1) institute an AIDS Public Awareness and Information Program,
(2) endorse the education of elementary and young adult students within the school system regarding the mode of transmission and prevention of transmission of the human immunodeficiency virus (HIV),
(3) address, through the Council on Ethical and Judicial Affairs, the patient confidentiality and ethical issues raised by known HIV antibody positive patients who refuse to inform their sexual partners or modify their behavior,
(4) work with various state societies in seeking to delete legal requirements for consent to medically indicated HIV testing which are more extensive than requirements generally imposed for informed consent to medical care,
(5) assist states in their efforts to take whatever actions are necessary to allow blood banks and health departments to share information for the purpose of locating and informing persons who have any transmissible blood-borne disease,
(6) seek greater involvement and adequate funding from the state and national levels for immediate development and implementation of AIDS/HIV educational programs,
(7) work with concerned groups to establish appropriate and uniform policies for neonates and pregnant adolescent school children with AIDS and AIDS-related conditions,
(8) lobby for federal, state and local governments to allocate funds for AIDS education programs in schools, colleges and news media,
(9) expand its work with AIDS public service announcements to include messages on abstinence, condom usage, and safer sex for distribution to media that specifically targets high risk groups."

Dispensing by Physicians

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association support the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines."

Condemnation of Certain Practices of Pharmaceutical Companies

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association reaffirms its adherence to Opinion 6.06 entitled 'Fee Splitting: Drug Prescription Rebates' to wit:

'A physician may not accept any kind of payment or compensation from a drug company for prescribing its products. The physician should keep the following considerations in mind:

(1) A physician should only prescribe a drug based on his reasonable expectations of the effectiveness of the drug for the particular patient.
(2) The quantity of the drug prescribed should be no greater than that which is reasonably required for the patient's condition.' *Current Opinions — 1986;* and be it further

RESOLVED, That said Opinion 6.06 should apply as well to the prescribing of Medical Devices; and be it further

RESOLVED, That this action be widely disseminated."

A National Study of Resource-Based Relative Value Scales for Physician Services: Project Status

The AMA House of Delegates adopted a Board of Trustees report that presents the status of the Association's involvement in a study of resource-based relative value scales for physician services. The report concludes that current developments in health care financing suggest that potential uses for a new RVS include application within new delivery systems, many of which involve capitation at some level, and development of Medicare and other third-party payor fee schedules. There are several potential uses of an RVS in capitation. One such use is in the calculation of capitation payment rates. A second application is in the determination of physician payment levels through fee schedules. Under current Administration plans, capitation for Medicare beneficiaries would be through a system in which enrollees could choose to receive their medical care from a health maintenance organization (HMO), competitive medical plan (CMP), preferred provider organization (PPO), or traditional Medicare fee-for-service physicians. Within such delivery systems as HMOs, CMPs, or PPOs, both physicians and plans could use a resource-based RVS as a basis for payment negotiations.

Recognizing that there are

several implementation issues yet to be resolved, the Board remains convinced that an RVS resulting from this study could be the basis for a Medicare physician reimbursement system that would be acceptable to the federal government, Medicare beneficiaries and medicine. The Board continues to emphasize, however, that the AMA is not committed to support any RVS implementation that would violate AMA policies, especially the Association's long-standing position against mandatory acceptance of third-party payment as payment in full.

The Board will continue to inform both the House of Delegates and the Federation about the overall progress of the RVS project. These efforts will continue through the conclusion of the project in July 1988. In addition, the Board will inform the House of any attempts to implement an RVS resulting from this project, and it will endeavor to ensure that such implementation is appropriate and not detrimental to medical care quality and access.

Hospitals Limited to Participating Physicians

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association advise its members that the decision of whether or not to be a 'participating' physician in Medicare is a personal choice; and be it further

RESOLVED, That the AMA use all appropriate means to rescind those recently enacted regulations and statutes which unfairly discriminate against health care providers, and jeopardize the quality, availability and affordability of health care for the aged and the infirm; and be it further

RESOLVED, That the AMA request Congress to return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965; and be it further

RESOLVED, That the American Medical Association specifically request Congress to rescind the "incentive" in the Omnibus Budget Reconciliation Act of 1986 regarding hospital referral of Medicare patients to participating physicians; and be it further

RESOLVED, That the American Medical Association work to amend the Medicare law to eliminate any financial incentives to Medicare carriers for signing up large numbers of physician providers; and be it further

RESOLVED, That the American Medical Association specifically seek to rescind, before its effective date of October 1, 1987, the Omnibus Budget Reconciliation Act of 1986 provision that requires a non-participating physician who performs an elective surgical procedure on an unassigned basis for a Medicare beneficiary to provide the beneficiary in writing the estimated approved charge under Medicare, the excess of the physician's actual charge over the approved amount and the coinsurance applicable to the procedure."

Discrepancies in Maximum Allowable Charge Calculations

The AMA House of Delegates adopted a Council on Medical Service report that suggests that physicians having problems with Medicare maximum allowable actual charge policies communicate directly with the appropriate carrier, and if necessary, with HCFA. The report notes that there are at least three possible reasons for such discrepancies:

(1) Carriers use the *median* of physician charges during the 1984 base period in calculating the MAAC for each service. However, many physicians may have used the *weighted average* of such charges in their own calculations (as they are allowed to do) to eliminate or minimize any rollback of their allowable charges during 1987. Carriers are required to recognize a MAAC based on either figure.

(2) The carrier may be unaware that the physician had charges for a particular service during the base period and accordingly has set the MAAC for that service at the 50th percentile of the customary charges for that service by non-participating physicians, as required by the law. In addition, it has been reported that some carriers are erroneously requiring *three* charges to compute the MAAC for a particular service. While three charges are required to establish a physician's customary charge profile, one charge during the base period is sufficient for purposes of calculating a MAAC.

(3) A discrepancy may have resulted from coding errors involved in the carrier's conversion to the AMA's CPT-4 procedural coding system, or from simple errors in recording charges during the base period.

Medicare Reimbursement

RESOLVED, That the AMA seek to assure that all Medicare fiscal intermediaries send to non-participating physicians adequate information for calculating MAAC levels; and be it further

RESOLVED, That the American Medical Association support any individual component society's legal efforts to prevent passage or overturn any state law that restricts the right of physicians to contract for services rendered to their patients provided:

(1) That the state applies to the AMA,

(2) That the Board of Trustees agrees that the litigation is meritorious,
(3) The Board will determine the extent of the support,
(4) If the Board of Trustees determines that the request is without merit they will inform that state of the difficiencies of its approach."

Payment for Physician's Services

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association reaffirm the physician's obligation to compassionately consider the patient's ability to pay in setting a fee; and be it further

RESOLVED, That the American Medical Association reaffirm the physician's right to set a fair fee for his/her services and to contract directly with the patient for provision of those services; and be it further

RESOLVED, That the AMA reaffirm the principle that payment schedules adopted by third party payors shall be construed as schedules of benefits to their covered insureds except in cases where physicians have voluntarily contracted with the insurer to accept those benefits as payment in full for services rendered."

Change in Criteria for Rural Referral Center of Designation

The AMA House of Delegates adopted a Board of Trustees report that opposes any federal government action to change rural referral center designations that might adversely affect access to or quality of care provided by the centers. The House of Delegates also adopted a Council on Medical Services report which makes the following recommendations for attracting more physicians to rural communities:

(1) Financial inducements — such as deferred student loan payments, practice grants and tax exemptions — in return for a period of service;
(2) Improved communications systems linking rural facilities with regional hospitals;
(3) Expanded state medical society placement services and other activities; and
(4) Dispersion of residency programs into rural areas.

In addition, the AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the AMA support legislation that would more adequately reimburse rural hospitals under the Prospective Pricing System (PPS) by reducing the urban/rural payment differential; and be it further

RESOLVED, That the AMA work with the Health Care Financing Administration to assure that flexibility and judgment are exercised in the interpretation and application of Medicare Conditions of Participation for rural hospitals which emphasize patient outcomes based on the available sources."

Report of the Special Task Force on Professional Liability and Insurance and the Advisory Panel on Professional Liability

The AMA House of Delegates adopted a Board of Trustees report that contains a status report submitted jointly by the AMA Special Task Force on Professional Liability and Insurance and its Advisory Panel on Professional Liability. This report updates activities undertaken since the first of the year and reports on federal legislation and the re-introduction of the AMA's bill into the current Congress. In addition, it cites the strong quality assurance activities of the Association. Of major significance, it reports on the status of development of alternatives to tort reform and the ongoing activities of the AMA/Specialty Society Medical Liability project.

In addition, the House of Delegates referred seven resolutions regarding professional liability to the Board of Trustees for a report back at the 1987 AMA Interim Meeting.

Physician Collective Bargaining

The AMA House of Delegates referred the following resolution to the Board of Trustees:

"**RESOLVED,** That the American Medical Association draft and introduce appropriate legislation to effect changes in federal antitrust law to allow physicians to collectively bargain; and be it further

RESOLVED, That the AMA petition the National Labor Relations Board to broaden the definition of "employee" in its rulings and interpretation of the NLRA so that physicians can be included within the definition."

Tax Law Changes

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association seek early Congressional consideration to:

(1) Correct inequities in the Tax Reform Act of 1986, including the excise penalty tax on excess retirement distribution, the excise tax on excess retirement accumulation, the requirement of 10-year plan participation, the requirement of plan participation by the lessee of 40 percent of all employees; and
(2) Re-establish IRA rules as under the previous law."

Resident Physician Working Hours/Supervision

RESOLVED, That the AMA believes that the establishment of rigid requirements for working hours, type and scope of supervision, and volume of clinical

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OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

First District
Stanley J. Lucas, MD
2905 Burnet Avenue
Cincinnati, Ohio 45219
Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren

Second District
William J. Marshall, MD
2600 Far Hills Avenue
Dayton, Ohio 45419
Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby

Third District
Thomas R. Leech, MD
718 W. Market St., Suite 050
Lima, Ohio 45801
Allen, Auglaize, Crawford, Hancock, Hardin, Logan, Marion, Mercer, Seneca, Van Wert, and Wyandot

Fourth District
John A. Devany, MD
2743 W. Central Avenue
Toledo, Ohio 43606
Defiance, Fulton, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Williams, and Wood

Fifth District
Henry G. Krueger, MD
24700 Lorain Road
North Olmstead, Ohio 44070
Ashtabula, Cuyahoga, Geauga, and Lake

Sixth District
J. James Anderson, MD
5204 Mahoning Ave., Suite 103
Youngstown, Ohio 44515
Columbiana, Mahoning, Stark, and Trumbull

Seventh District
Nermin D. Lavapies, MD
1220 Hughes Avenue
Martins Ferry, Ohio 43935
Belmont, Carroll, Coshocton, Harrison, Jefferson, Monroe and Tuscarawas

Eighth District
John F. Kroner, Jr., MD
Box 708
Athens, Ohio 45701
Athens, Fairfield, Guernsey, Licking, Morgan, Muskingum, Noble, Perry, and Washington

Ninth District
Thomas P. Price, Jr., MD
Holzer Medical Clinic
385 Jackson Pike
Gallipolis, Ohio 45631
Gallia, Hocking, Jackson, Lawrence, Meigs, Pike, Scioto, and Vinton

Tenth District
H. William Porterfield, MD
3650 Olentangy River Rd.
Columbus, Ohio 43214
Delaware, Fayette, Franklin, Knox, Madison, Morrow, Pickaway, Ross, and Union

Eleventh District
Charles G. Adams, MD
5896 Liberty Avenue
Vermilion, Ohio 44089
Ashland, Erie, Holmes, Huron, Lorain, Medina, Richland, and Wayne

Twelfth District
Jack L. Summers, MD
75 Arch Street
Suite B2
Akron, Ohio 44304
Portage and Summit

responsibility for physicians in programs of graduate medical education by administrative regulation or by legislation at state or national level is improper and has the potential to interfere with the provision of medical care of high quality and with the educational process in teaching hospitals and other settings; and be it further

RESOLVED, That the AMA recognizes the importance of the graduate medical education of physicians and the unique ability of the medical profession to propose policies which simultaneously protect the welfare of patients and ensure the high quality of graduate medical education; and be it further

RESOLVED, That the AMA direct the existing Council on Medical Education task force on graduate medical education to give prompt attention to these issues, to seek consultation from experts within and without the AMA, and to prepare for the House of Delegates at the Interim 1987 Meeting a full report and a set of guiding principles."

Proposed Models of Nursing Services for Independent Nurse Practice in Hospitals and Communities

The AMA House of Delegates adopted a Board of Trustees report that describes plans of the American Nurses Association to secure an independent role for nurses in delivery of care in institutions, in the community, and in home care. The report states that the AMA opposes the establishment of two levels of care for the public and recommends

(1) that state medical associations be alert to legislative initiatives that would establish a two-tiered system, and

(2) that state and county medical societies continue to develop initiatives to assure access to physician care for needy populations.

Ambulatory Care Joint Ventures

The AMA House of Delegates adopted a Board of Trustees report that responds to a resolution submitted at the 1986 AMA Annual Meeting. The report cites current and past activities on various types of joint ventures. It also notes that in January 1987 the Committee on Medicolegal Problems and the Council on Ethical and Judicial Affairs published a monograph, "Physician-Hospital Joint Ventures."

The monograph sets forth the various organizational structures available to health care joint ventures, including ambulatory care centers. The structure agreed upon by parties to the joint venture will depend on a number of business and legal considerations, such as capital requirements, the need to allocate governance and control of both medical and non-medical matters, the manner of dividing profits and losses, any regulatory requirements applicable to the venture and/or the participants, antitrust considerations, tax consequences, securities law considerations, and liability concerns.

Credentials Files for Members of Hospital Medical Staffs

The AMA House of Delegates adopted a Board of Trustees report that proposes guidelines to assist medical staffs in developing policies with respect to the key issues involved in the management of medical staff credentials files: a single file for each member; location and content of the file; and access to the files. The report recommends that the AMA urge medical staffs to establish and incorporate into their bylaws policies covering the management and maintenance of credentials

files, and that the AMA encourage medical staffs to develop hospital-specific policies on credentials files.

Prevention of AIDS Control — an Interim Report

The AMA House of Delegates adopted an amended Board of Trustees report that outlines a comprehensive approach for the prevention and control of AIDS. Following are several of the recommendations included in the report:

(1) Mandatory testing of donors of blood and blood fractions, organs, tissues, semen and ova; inmates in federal and state prisons, immigrants to the United States, and military personnel;
(2) Routine voluntary testing with informed consent for the following types of individuals who are from areas with a high incidence of AIDS or who engage in high risk behavior such as:
    a) patients at sexually transmitted disease clinics and drug abuse clinics;
    b) pregnant women in their first trimester of pregnancy;
    c) people seeking family planning services;
    d) patients who require surgical or other invasive procedures (if the voluntary policy is not sufficiently accepted by such patients, the hospital and medical staff should consider implementing a mandatory program);
(3) As a matter of medical judgment, voluntary testing should be encouraged for individuals whose history or clinical status warrants this measure and anyone who is homosexual, bisexual or has a history of intravenous drug use or who is the sexual partner of anyone in these groups.

Notification of Physicians When a Patient is HIV Positive

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association:

(1) Identify risk factors and guidelines for hospitals, medical staffs and health workers appropriate to the care of AIDS and HIV-positive patients;
(2) Include in such guidelines policy that would enable physicians caring for patients with a positive HIV test to discuss with legal immunity and in a confidential manner these patients with other health care professionals who are also involved in their care, and assist state medical societies in changing state laws where such informational exchange is now prohibited;
(3) Distribute these guidelines widely and encourage medical staff and health workers to work closely with their hospital administrations and governing bodies in establishing appropriate hospital policy regarding AIDS and HIV-positive patients;
(4) Affirm its support for the dignity and self-respect of all patients;
(5) Oppose all acts of categorical discrimination against patients because of their medical condition."

Product Identification and Generic Drugs

The AMA House of Delegates adopted the following amended resolution:

"**RESOLVED,** That the American Medical Association work with the appropriate organizations to:

(1) Develop a coding system for the identification of all solid medication forms;
(2) Imprint, when feasible, each tablet, capsule or other solid dosage form of generic prescription drug with its unique code and the name or other distinctive mark identifying the manufacturer; and
(3) Compile this coding system into a reference and disseminate it to physicians, pharmacists and law enforcement agencies in an appropriate manner."

Issues Relating to the Economic Representation of Physicians

The AMA House of Delegates adopted a Board of Trustees report that reviews the issues raised by an earlier resolution calling for legislative change to permit employed physicians to unionize. The report concludes that employed physicians can organize to bargain collectively with health care employers to improve their economic conditions and the quality of health care delivered to patients. Physicians need not join or form national labor unions to assert their collective rights. Rather, they can organize on a more local level to preserve and protect their autonomy and interests.

The AMA can assist physicians in their organization and bargaining efforts. First, through involvement in case-by-case adjudications and NLRB rule-making procedures, the AMA will attempt to expand the scope of non-supervisory, employed physicians to permit the organization and representation of more physicians under the labor laws. Second, in a carefully controlled way, the AMA can assist the organization and bargaining efforts of employed physicians by providing needed guidance and expertise. Finally, the AMA, and medical societies

generally are in a better position, both legally and professionally, than national labor unions to assist physicians in their collective bargaining.

1987 AMA Public Awareness Activities

The AMA House of Delegates adopted a Board of Trustees report that provides a review of the comprehensive communications and public awareness programming now in place. Individual products and activities are reviewed regularly to determine their timeliness, how well they serve the stated missions of the AMA, and how well they support Association policies and priorities.

In addition to its active participation in media tours, community speaking forums, and other related activities, the Board has reviewed various aspects of the Association's communications and public awareness activities at each of its meetings over the past four years. The Board of Trustees intends to continue this review and will periodically report to the House of Delegates.

Peer Review Organization Program Status

The AMA House of Delegates adopted a Council on Medical Service report that provides information concerning recent Association activities with respect to the PRO program and discusses a number of current PRO program initiatives. The report also presents a discussion of current PRO program issues along with the views of the Council concerning several issues. Included in the report's discussion is a detailed description of the recently achieved agreement between the AMA, Health Care Financing Administration, Inspector General, and American Association of Retired Persons concerning new procedures for PRO handling of sanction cases. This agreement, and the resulting government directive to PROs, assures greater due process protections for physicians.

The AMA House of Delegates also adopted two resolutions on this subject:

Funding of Education Through the Peer Review Organizations

"**RESOLVED,** That the American Medical Association encourage the Secretary of Health and Human Services to stress education of physicians toward higher quality and cost effective medical practice in policy and funding of the Peer Review Organizations in the Prospective Payment System."

Revision of PRO Sanction Protocol

"**RESOLVED,** That the American Medical Association seek amendments to the Peer Review Organization (PRO) Law (PL 97-248) which would require that:

(1) The definition of 'gross and flagrant' be reviewed and modified to include only those violations which cause the PRO to conclude that the continuation of medical practice by the physician would constitute an immediate danger to the health, safety or well-being of Medicare beneficiaries; and
(2) If an 'imminent hazard' to the health and welfare of Medicare beneficiaries exists, a special expedited hearing process should be statutorily created for immediate action prior to, if possible, or immediately after a sanction decision."

Home Health Care

The AMA House of Delegates adopted an amended Board of Trustees report which recommends that the AMA:

(1) reaffirm its support of home health care as an alternative to hospital, nursing home or institutional care;
(2) encourage physicians to take a more active role in the provision of home health care;
(3) seek modifications in the Medicare regulations for home health care, so that those regulations include appropriate standardized definitions and instructions to fiscal intermediaries;
(4) make every effort to improve patient accessibility to home health services by seeking modifications in the Medicare regulations to provide coverage for the care of homebound patients by qualified individuals working under the supervision of the patient's attending physician;
(5) Continue to monitor the adequacy of the home health care system to meet the accessibility needs of homebound patients, and develop additional recommendations as appropriate
(6) Convey to the Health Care Financing Administration the results of the Association's development of what constitutes extraordinary case management services, with an emphasis on those services specific to home health care."

On-Site Emergency Care

The AMA House of Delegates adopted a Board of Trustees report that considers the advantages and disadvantages of on-site resuscitation efforts versus rapid transferral of accident victims to definitive care. The AMA Commission on Emergency Medical Services has identified the following factors that should be considered by pre-hospital personnel in making the decision either to provide extended care in



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(See Brief Summary of Prescribing Information on the next page.)

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Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
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5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26) *100 Systems (NDC 0083-2105-30)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

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C I B A

AMA Report . . . *continued*

the field or to rapidly evacuate the trauma victim:
(1) The type, severity and anatomic location of the injury;
(2) the proximity and capabilities of the receiving hospital;
(3) the efficiency and skill of the paramedic team; and
(4) the nature of the environment, e.g., rural or urban.

Because of the variability of these factors, no single methodology or standard operating procedure can be applied to all accident situations. Trauma management differs markedly between locales, settings, and the types of patients receiving care. For these reasons, physician supervision and direction of prehospital services is essential.

Trauma Center Designation

The AMA House of Delegates adopted a Board of Trustees report that responds to two resolutions submitted at the 1986 AMA Annual Meeting. The resolutions ask the AMA to study the impact of designated regional trauma centers on the efficacy of the delivery of emergency medical services and to support the development of regional trauma care systems and trauma center designation. The report notes that both resolutions have been reviewed by the AMA Commission on Emergency Medical Services. The Commission found that at least 29 studies have appeared in the medical literature demonstrating the effectiveness, in reducing trauma death, of a systems approach to trauma care. In view of these completed studies, the Commission concludes than an independent study by the AMA is not warranted. Based on these studies, the Commission recommends that the AMA support the development of regional trauma care systems and trauma center designation.

Negotiation Regarding Quality of Care

The AMA House of Delegates adopted a Council on Medical Service report that recommends:
(1) That the AMA continue to encourage state medical associations to seek the enactment of statutes creating PRO and payor liability in their jurisdiction.
(2) That state and local medical societies be urged to pursue activities designed to expand local physician involvement and influence in the development and application of peer review criteria.
(3) That local medical societies not currently so involved consider the feasibility of sponsoring or cosponsoring their own quality review program which could be offered to area employees and other health care payors.

Daytime Use of Low Beam Headlights

The AMA House of Delegates referred the following resolution to the Board of Trustees for a report at the 1988 Annual Meeting:

"**RESOLVED,** That the American Medical Association encourage the daytime use of low beam headlights on all present vehicles; and be it further

RESOLVED, That foreign and domestic manufactureres be encouraged to install a system on all vehicles sold in the United States which will automatically turn on low beam headlights with the ignition switch."

Encroachment of Third Parties in Patient-Doctor Control of Medical Care

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association continue its commitment to inform

physicians and the lay public, who constitute the patient population, regarding the potential limitations of the quality of medical care that may ensue as the result of control by government and/or large hospital corporations and insurance companies; and be it further

RESOLVED, That the Association do so through its education facilities, journals, and its public relations department."

Health Policy Agenda for the American People

Culminating five years of effort to re-examine the basic values upon which the health care system is based, the AMA House of Delegates considered 195 recommendations of the Health Policy Agenda for the American People.

Development of these recommendations involved over 425 representatives from 172 different health, health-related, business, government and consumer groups. Their mission was to examine the immediate concerns of today, as well as the issues that will be confronting the health sector into the next decade and the next century. Following are some of the recommendations which were adopted by the AMA House of Delegates:

Recommendation 91

Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

Substitute Recommendation 92

Individuals should, at their own option, provide instructions regarding their wishes in the event of the incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interest of the patient.

Recommendation 93

A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

Recommendation 94

Conflicts between a patient's right to privacy and a third-party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

Substitute Recommendation 95

Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

Recommendation 96

A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

Recommendation 97

Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.

Substitute Recommendation 116

Tort system modifications and alternative dispute resolution systems should be evaluated to determine the extent to which they provide expeditious, fair, and reasonable compensation in a cost-effective manner for injuries that occur as a result of negligence.

Substitute Recommendation 117

A demonstration study of a patient compensation fund, which would replace the tort system as the initial entry point into the system, should be explored by a state or group of states. In this demonstration study, a broadly representative panel should make expeditious determinations about compensation for injuries arising from medically related events. Payment should be made according to a predetermined schedule based on the severity of the injury and/or should include limitations on the compensation for pain and suffering. The patient compensation fund should be jointly financed by the public and private sectors; the initial portion of awards should be paid by the public sector, subject to a cap per case and reduced by the value of collateral resources. In the event that the injured or the defending party is not satisfied with the determination made by the panel, then that party should have the option to reject the panel's decision and to sue under state law, subject to more stringent standards established to parallel

the compensation system (i.e., when a plaintiff rejects the panel's award, tougher tort law standards would be triggered, and when a defendant rejects the panel's award, current tort law standards would govern the case). A substantial monetary penalty should be imposed when the result of a lawsuit is less favorable to the party that rejected the panel's decision. If both parties accept the determination of the panel, then access to the tort system would be waived. A report, which includes a study of the costs, the number and types of cases, any cost-shifting, and the degree of satisfaction of those involved in the system, should be prepared as the basis for further decisions.

Recommendation 118

State licensure/disciplinary boards should be given full and extensive disciplinary powers within constitutional limits. Members of state licensure/disciplinary boards should be granted immunity for actions performed in good faith, and they should be indemnified at state expense against any legal action brought under either state or federal law when they are acting in good faith in performance of their duties.

Recommendation 119

Health care professional associations and health care facilities should be required to notify state licensing/disciplinary boards when disciplinary action is taken against a health care professional.

Recommendation 120

Health care professionals should report personal knowledge of any conduct that they reasonably believe constitutes grounds for disciplinary action to the state licensing/disciplinary board.

Recommendation 121

State licensing/disciplinary boards should be required to review judgments and settlements against health care professionals who have been judged negligent by the courts or who have settled claims which exceed a predetermined amount.

Recommendation 122

Information systems should be expanded to allow prompt transfer among jurisdictions of pertinent licensure and disciplinary information about health care professionals.

Substitute Recommendation 123

In the case of allied health professions, malpractice decisions and disciplinary actions of licensing boards and certification agencies should be communicated to a central clearinghouse. Health care facilities should have access to the resources of the clearinghouse to screen prospective employees.

Recommendation 124

State licensure/disciplinary boards should be adequately funded to allow for appropriate investigation and disposition of complaints regarding quality of care and/or the competence of health professionals.

Substitute Recommendation 135

Health care recipients should have free choice of health care providers from among available resources. The following information should be made available through appropriate channels to the public: each professional group's standards of education and training, standards of practice, scope of practice, and standards of competence; licensure standards, scope of practice permitted by the license, and licensed practitioners; and the treatment outcomes of health care providers.

Substitute Recommendation 136

Individual providers should be able to determine what their prices will be for services offered.

Recommendation 137

Health care recipients, individually and collectively, have the right and the responsibility to negotiate health care prices with providers when possible.

Recommendation 138

Individual providers and third-party payors should have the right to enter into contracts with each other. They should be allowed to designate their own bargaining agents in the negotiation process, and bargaining should take place at the national, regional, state, and/or local level as appropriate to the third-party payors involved. Providers and third-party payors should have the right to negotiate both the level of reimbursement and the payment mechanism.

Recommendation 139

Health care providers should consider the financial circumstances of health care recipients and should accept reduced fees when warranted.

Recommendation 140

Health care professions should have a role in the review of exorbitant fees that may be charged by their respective practitioners.

Recommendation 141

A basic benefit package for all Americans should be defined to serve as the basis for private health insurance plans and for public programs that finance health care.

Recommendation 142

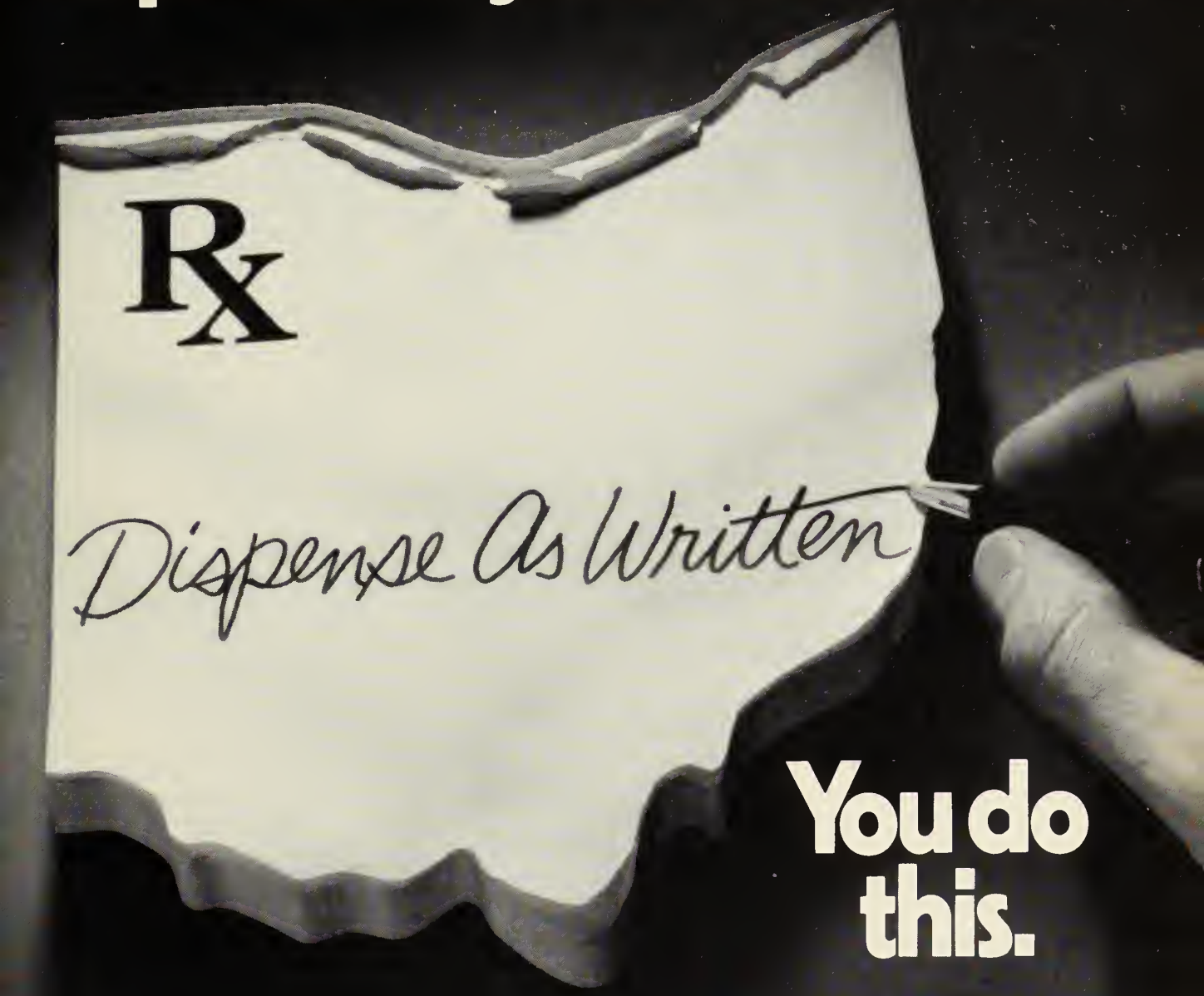
Third-party payors should provide coverage of catastrophic costs.

Recommendation 143

Coverage for long-term health care services should include various options, such as hospital care, nursing home care, hospice

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chlordiazepoxide HCl/Roche ℞

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Please see adjacent page for a summary of product information.

LIBRIUM® Ⓝ
chlordiazepoxide HCl/Roche
5-mg, 10-mg, 25-mg capsules
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended
Contraindications: Known hypersensitivity to the drug
Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.
***Usage in Pregnancy*: Use at minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido – all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral – Adults.* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*, severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl/Roche) *Capsules*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500; Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10. Libritabs® (chlordiazepoxide/Roche) *Tablets*, 5 mg and 10 mg – bottles of 100 and 500; 25 mg – bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.
PI 0286

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AMA Report . . . *continued*

care, home care, respite care, and day care. Coverage for these long-term health care services should be financed through payment systems. The primarily social service aspects of long-term care — long-term custodial or institutional care and outpatient personal care — should be financed separately from health care services.

Substitute Recommendation 144

Alternate insurance plans, including indemnity, with different schedules of deductibles, coinsurance, and premiums, should be available to beneficiaries so that they are aware of the financial tradeoffs associated with different plans. Third-party payment systems should use deductibles and coinsurance as financial incentives for health care recipients to use health care resources in an appropriate manner. Cost-shifting should not result in an undue financial burden for the health care recipient.

Recommendation 145

Recipients of health care should recognize their own responsibilities for avoiding unhealthy lifestyles and should be prepared to bear the financial consequences of their decisions. Health care providers should encourage health care recipients to engage in healthy lifestyles and should practice and promote preventive health care. Third-party payors should structure health insurance premiums to reward insureds who pursue healthy lifestyles. Employers, employee groups, and third-party payors should sponsor the development and presentation of employee educational programs to promote healthy lifestyles among employees and beneficiaries.

Substitute Recommendation 146

Medical associations, employer, employee groups, and third-party payors should collaborate to structure health care plans to provide necessary utilization of services. To foster freedom of choice and competition, employers, employee groups, and third-party payors should structure programs which maintain access to fully licensed providers under direct medical supervision, and various delivery systems.

There are many excellent reports presented to the AMA House of Delegates covering a wide range of subjects that are of interest to physicians. These reports, prepared by the AMA Board of Trustees, councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follow. If you would like a copy of these reports, please contact the OSMA office.

1. Capitation as a Payment Mechanism for Medicare.
2. Physician Reimbursement Under Medicare
3. Special Payment Arrangements for Low-Income Medicare Beneficiaries
4. Health IRAs
5. Health Care for Newly Legalized Alien Residents

continued on page 647

Please send me the following AMA report(s) listed in the Summary of Actions Report of the 1987 AMA Annual Meeting:
Report Number(s) _____
Name _____
Address _____
_____
SLW

Send to:
OSMA
600 S. High St.
Columbus, OH 43215

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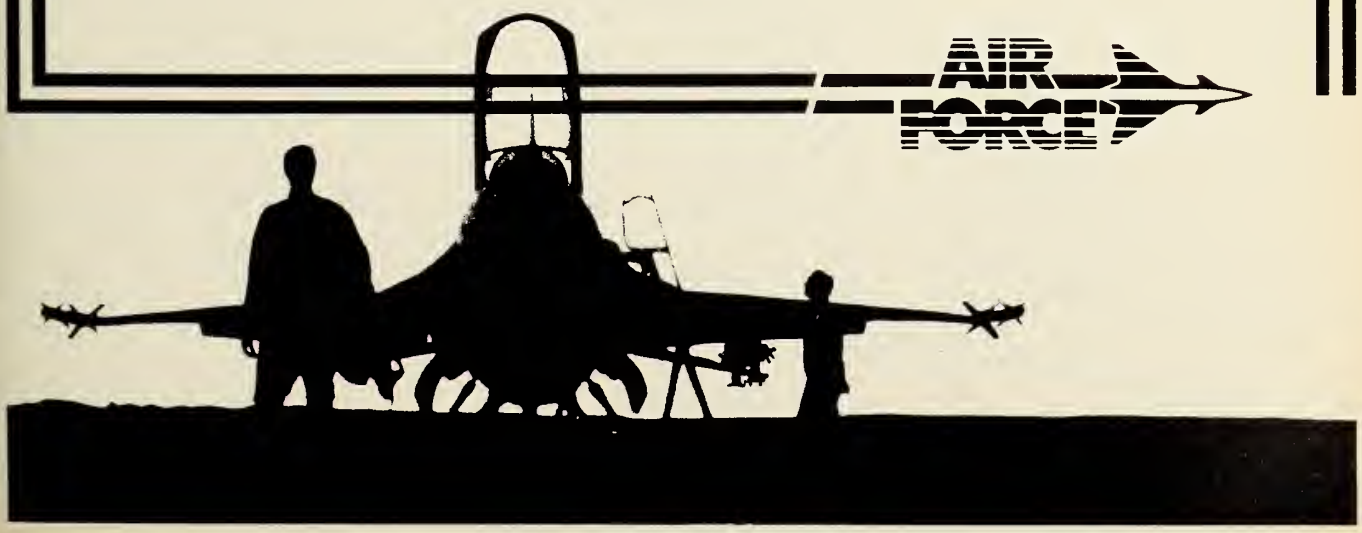
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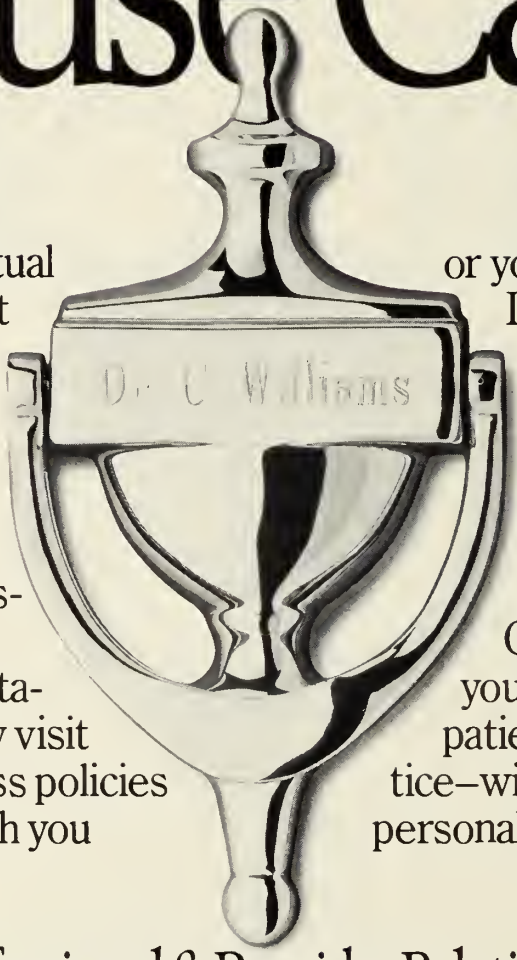
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'Outreach' open to all

By Katherine E. Wisse, Director, Department of Membership Development

You can add to the strength of your association by contacting and convincing your non-member physician colleagues to join the OSMA. As Thomas W. Morgan, MD, chairman of the OSMA Membership Committee, pointed out at the association's Annual Meeting — "after hearing all the excuses for not joining, (organized medicine) I have yet to hear a really good one." By participating in the OSMA's peer-to-peer membership recruitment program (Outreach) you can join the ranks of successful recruiters:

Claire V. Wolfe, MD
Academy of Medicine of Columbus and Franklin County
Recruited: 71 members

Donavin A. Baumgartner, Jr., MD
Academy of Medicine of Cleveland
Recruited: 19 members

Joseph L. Kloss, MD
Summit County Medical Society
Recruited: 11 members

as well as others who continue to make the program a success. In addition to this year's top recruiters, for example, the following were among 20 delegates/alternates representing 12 counties who recruited members and received an award for their efforts.

Thomas W. Morgan, MD, Gallia; William D. Sawyer, MD, Montgomery; William H. Gates, MD, Hamilton; Thomas J. Hall, MD, Licking; Charles A. Peter, MD, Summit; Richard Villereal, MD, Scioto; Herman I. Abromowitz, MD, Montgomery; William Dorner, Jr., MD, Summit; Roland A. Gandy, Jr., MD, Lucas; Edmund W. Jones, MD, Hamilton; John F. Kroner, Jr., MD, Athens; Herbert G. Magenheim, MD, Hamilton; Walter E. Matern, MD, Hamilton; William A. Millhon, MD, Franklin; John W. Ray, MD, Muskingum; William B. Selnick, MD, Clermont; Joseph Sudimack, MD, Trumbull.

These members and their counties are to be congratulated for their efforts to increase OSMA support among the physicians of Ohio.

The Outreach program has been in effect for three years with OSMA delegates and alternates enthusiastically participating in the program. As a result of their efforts, 87 members joined in 1985 and 128 joined in 1986. The 1987 program is still underway.

In addition to the financial support from these new members, "the power that comes from speaking with a united voice gives medicine an advantage we cannot afford to lose," as Dr. Morgan pointed out when updating the House of Delegates on membership at the OSMA Annual Meeting in May.

To repeat a few statistics:

- OSMA membership is increasing annually — from 19,191 in 1985 to 19,877 in 1986
- AMA membership grew from 15,724 in 1985 to 16,188 in 1986.
- Student and resident members are a significant part of these totals. There were 3,198 student and resident members in 1986.

Support of the AMA is important to maintain Ohio's representation at the AMA House of Delegates. OSMA now has 11 consecutive years of AMA membership growth.

As Dr. Morgan pointed out, "membership is still the name of the game." Even though the full dues-paying members continue to increase we "still have not been able to crack the 4,000 to 5,000 non-member nucleus."

To do so, the OSMA needs the help of all members. That's why the "Outreach" program is being opened up to the entire membership. You can earn a marble paperweight with the OSMA seal if you are responsible for contacting and convincing just one of your non-member colleagues to join OSMA. You can earn a wool blazer if you are responsible for recruiting the most non-members. You can earn a sport jacket if you are responsible for recruiting the second highest number of members. For information about participating in the Outreach Program, contact the OSMA Department of Membership Development. If you do join in this Outreach program, it is important to let the department know whom you have contacted so you will get the credit when your colleague joins.

Coming in October: *A profile of OSMA's new membership chairman, Thomas R. Leech, MD, and his views on membership.*

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*These performance rankings were for total return (price appreciation plus reinvested dividends). Yield and share price will vary. This performance occurred during a period of generally declining interest rates. Past performance is not indicative of future results. Securities products offered through New England Securities, a financial partner of The New England and member SIPC.

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OBITUARIES

KENNETH ALBERS, MD, Cincinnati; University of Cincinnati College of Medicine, 1966; age 47; died June 16, 1987; member OSMA and AMA.

ERNEST F. BRIGHT, MD, Boca Raton, FL; Harvard Medical School, Boston, MA, 1929; age 84; died June 12, 1987; member OSMA and AMA.

WALTER DE LA MOTTE, MD, Worthington; Friedrich-Wilhelms Universitaet Medizinische Fakultaet, Berlin, Germany, 1937; age 74; died June 13, 1987; member OSMA and AMA.

CHARLES A. GERACE, MD, E. Liverpool; Georgetown University School of Medicine, Washington, DC, 1938; age 75; died June 29, 1987; member OSMA and AMA.

RAYMOND HILSINGER, MD, Tucson, AZ; University of Cincinnati College of Medicine, 1933; age 81; died June 9, 1987; member OSMA and AMA.

J. WALTER JOHNSON, MD, Akron; Loyola University, Stritch School of Medicine, Maywood, IL, 1927; age 87; died July 3, 1987; member OSMA and AMA.

ALFRED M. KEIRLE, MD, Cincinnati; Cornell University Medical College, New York, NY, 1946; age 64; died June 22, 1987; member OSMA and AMA.

LUTHER M. KEITH, JR, MD, Columbus; University of Tennessee Center for Health Sciences, Memphis, TN, 1945; age 67; died June 19, 1987; member OSMA and AMA.

JOHN F. KUEHN, MD, Toledo; Loyola University Stritch School of Medicine, Maywood, IL, 1944; age 66; died June 27, 1987; member OSMA and AMA.

HAROLD E. RAY, MD, Xenia; University of Michigan Medical School, Ann Arbor, MI, 1929; age 83; died June 20, 1987; member OSMA and AMA.

EMERSON P. SHEPARD, MD, Lancaster; Ohio State University College of Medicine, 1925; age 87; died June 25, 1987; member OSMA and AMA.

HARRY J. TOURIGIAN, DO, Cleveland; Philadelphia College of Osteopathic Medicine, Philadelphia, PA, 1980; age 33; died June 4, 1987; member OSMA and AMA.

EARL FOREST WARD, MD, Toledo; Ohio State University College of Medicine, 1937; age 74; died July 3, 1987; member OSMA and AMA.

Continued from page 642

6. Risk Management
7. Drug Use by Athletes — An Interim Report
8. Prevention and Control of AIDS — An Interim Report
9. AIDS Status Report: Update on Epidemiology
10. Religious Exemptions from Immunizations
11. AMA Dues — 1988
12. Publication of CPT Minibooks
13. PRO Sanctions
14. Guidelines on Peer Review Activities — Status Report
15. AMA Women in Medicine Project — Progress Report
16. Outreach Program of Women Physicians — Progress Report
17. Issues in Employee Drug Testing

Continued from page 627

(Original Resolution read:
RESOLVED, That the OSMA-MSS request OSMA to investigate the effects of school-based birth control and school-based health/birth control clinics to determine if results of such clinics are desirable, and then to formulate a policy to support or oppose such clinics based on said investigation.)
MSS Assembly Action: Passed as amended.

CLASSIFIED ADVERTISING

Employment Opportunities

ASSOCIATE RESIDENCY PROGRAM DIRECTOR

The Northeastern Ohio Universities College of Medicine (NEOUCOM) Psychiatry Residency Training Program seeks a board certified psychiatrist to assume a major leadership role as an Associate Residency Program Director at Akron General Medical Center (AGMC).

AGMC is a 507-bed community hospital with a major teaching affiliation with NEOUCOM. The hospital has two units comprised of 58 adult psychiatric beds and an outpatient service.

Major duties will include teaching residents involved in adult inpatient and outpatient activities.

Salary is competitive, with an opportunity for private practice, research and teaching of undergraduate medical students. EOE/AAE

Direct inquiries to Moshe Torem, M.D., Akron General Medical Center, 400 Wabash Avenue, Akron, Ohio 44307.

BOARD-CERTIFIED ANESTHESIOLOGIST

Northeastern Ohio teaching hospital with an approved, four-year residency program in anesthesiology seeks a board-certified anesthesiologist with extensive interest and experience in research and teaching. Responsibilities will include clinical practice, house staff education and clinical investigation. Excellent salary and benefits leading to early partnership. Send curriculum vitae and references to: John G. Poulos, MD, Chairman, Department of Anesthesiology, Huron Hospital, 13951 Terrace Road, Cleveland, OH 44112.

CARDIOLOGY

Growing multispecialty group in NE Ohio seeks board certified/eligible cardiologist to expand the department. Contact D.L. Sheffield, Administrator, Ashtabula Clinic, 430 West 25th Street, Ashtabula, OH 44004, (216) 998-1212.

CENTRAL OHIO MULTISPECIALTY GROUP needs second family physician (BC/BE) for expanding practice. Modern family practice facility in attractive community. Reply Box 150, c/o OHIO Medicine, 600 South High Street, Columbus, OH 43215.

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The Lithotripter uses shock waves to bombard kidney stones into sand-like particles inside the body. The residue is then easily passed. Although the theory behind Lithotripsy is simple, the process is precise. The stone is pinpointed inside the body with fluoroscopy and shock wave firing is synchronized with the patient's heartbeat by electrocardiogram. Usually, the entire process takes about an hour.

As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

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For your brochures or other information about Lithotripsy and our kidney stone treatment program, call CAMC: in West Virginia at 1-800-654-0159; from out of state, call 304-340-7315.

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Chief of Service needed for a new innovative Geropsychiatric services system that includes a 20 bed inpatient unit and an aftercare program. The focus is on short-term psychiatric rehabilitation working closely with families and referring agencies. The successful applicant will be a Board Certified psychiatrist with training or experience in geropsychiatry. In addition, experience in administration of psychiatric units and programs is a plus. The Chief of Service should be able to work successfully with colleagues in a multiple admission, private, non-profit, psychiatric institution. For further details phone (216) 951-1177 or 1-800-438-4673. Send resumes to: Dr. Walter Poulshock, Ridgecliff Hospital, 35900 Euclid Avenue, Willoughby, OH 44094.

CLEVELAND SUBURBS. Seeking director, full-time and part-time physicians for urgent care facility. Multi-specialty back-up and air transport service. Attractive hours and compensation. Malpractice insurance provided. Benefit package available. Contact Emergency Consultants, Inc., 2240 South Airport Road, Room 38, Traverse City, MI 49684; 1-(800)-253-1795 or in Michigan 1-(800)-632-3496.

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Selected applicant will be Director of Trauma and Surgical Critical Care, responsible for developing clinical and laboratory projects pertaining to these areas. Additionally, the director will be heavily involved with both clinical responsibilities and graduate surgical education of surgical residents in our fully-approved residency program. Qualifications: Graduate of an AAMC-approved medical school, board eligibility/certification in surgery, fellowship in trauma with extensive critical care experience. Documented experience in clinical and laboratory research. Salary guarantee and extensive benefits. Reply to: Helmut Schreiber, MD, Chairman, Department of Surgery, Huron Hospital, 13951 Terrace Road, Cleveland, OH 44112.

EMERGENCY MEDICINE EDUCATION COORDINATOR — Immediate opening for full-time position at a 500-bed community hospital with 32,000 visits annually. The applicant should have completed a residency in Emergency Medicine or possess ABEM certification. Responsibilities include clinical supervision of Emergency Medicine, General Surgical, Family Practice residents. Participation in Trauma Service, Emergency Medicine Residency development, Occupational Health Program and EMS training programs desirable. Fairview General is a progressive Level I facility located in affluent Cleveland Westside suburbs, one-half hour from Lake Erie. Remuneration is $120k yearly. Submit CVs to: Joseph J. Badal, MD, FACEP, Chairman, Department of Emergency Medicine, Fairview General Hospital, 18101 Lorain Avenue, Cleveland, Ohio 44111, (216) 476-7312.

EMERGENCY MEDICINE — Emergency Department Physicians needed for high and low volume hospitals in rural and metro areas. We offer competitive compensation with liability insurance procured. If interested in positions in Ohio or Illinois send CV to Robert Beck, Coastal Emergency Services, Inc., 6230 Busch Boulevard, Suite 300, Columbus, OH 43229; or call (614) 436-0418 collect, west of the Mississippi, (800) 633-9964 east of the Mississippi, (800) 551-3859 in Ohio.

FAMILY PHYSICIAN: Outstanding opportunity for BC/BE Family Physician in community six miles north of Cincinnati. Thriving practice, income guarantee/benefits, new facilities and superb hospitals/consultants. Kathleen Lang, MD, 1-(513)-738-5206 (collect) weekdays 10-5.

FAMILY PRACTICE ASSOCIATION of a suburban Toledo-area hospital requires a Board Certified family practitioner for an Assistant Directorship with both teaching and patient responsibilities. Fully AMA-approved residency program is nicely located in a modern 15,000 square foot facility next to the parent hospital. Competitive salary with ample fringe benefits. Call or write R.E. Scherbarth, MD, Director — FPA, Flower Memorial Hospital, 5200 Harroun Road, Sylvania, OH 43560, (419) 885-1444, Ext. 2910.

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— No call. Partnership 2nd year, excellent fringe package.

NW OHIO

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Pleasant community, sophisticated hospital facilities, plus good income potential. Office available, competitive recruitment package. Contact Bruce Lauer, Good Samaritan Medical Center, 800 Forest Avenue, Zanesville, Ohio 43701. (614) 454-5875 or 1 (800) 322-4762.

FAMILY PRACTICE — Opportunity to join a group practice in family and/or internal medicine. Currently have six locations in Greater Cincinnati area. Excellent benefits and productivity incentives. Stay one year or make it a career. Call (513) 651-5546 for application or send CV to: Physician Care, Inc., 617 Vine Street, Suite 1320, Cincinnati, OH 45202.

FAMILY PRACTICE PHYSICIAN — MERCY HOSPITAL, a 350-bed teaching hospital is seeking a BE/BC Family Practitioner to join a busy, established practice. This is an excellent opportunity offering an attractive practice package. For further details about this exciting practice opportunity, please contact or forward CV to: Wendy Tossell, Physician Development Coordinator, Mercy Hospital, 2200 Jefferson Avenue, Toledo, Ohio 43624 or call: (419) 259-1504.

FAMILY PRACTICE PHYSICIAN currently needed for growing south Dayton practice to replace previously retired physician. Patient volume exceeds 26,000. Two-physician team offers full partnership opportunity and attractive salary guarantee with income supplement available through occupational medicine. Paid liability, Board dues, generous vacation. Office 1½ miles from hospital and convenient to its teaching affiliate. Full specialty consultation available. Association with 11-physician group for on-call coverage. No obstetrics. Contact or send CV to: R.S. Zanowick, MD, 945 East Central Avenue, Miamisburg, OH 45342, 513-866-2494.

FAMILY PRACTICE: Rural northwest Ohio community within 25 minutes of Fort Wayne, Indiana needs a board certified or board eligible Family Practitioner. Modern and up-to-date practice facility for acute and continual primary care. Administrative and practice expense furnished for 1st year. No capital purchases or investment required. Excellent base pay and extended income potential. Practice affiliated with 3 other board certified family practitioners. Please send CV or call for more information to: W.R. Plassman, Community Memorial Hospital, 208 North Columbus Street, Hicksville, OH 43526, 419/542-6552.

FAMILY PRACTITIONER (BE/BC) excellent primary care opportunity with expanding hospital sponsored physician group. Southwest Ohio location. Progressive philosophy, comprehensive salary and benefit package. Reply with CV to Reply Box 144, c/o *OHIO Medicine,* 600 South High Street, Columbus, OH 43215.

FAMILY PRACTITIONER NEEDED: to start solo practice in northwestern Ohio. Ample opportunity for call coverage available. Attractive salary/benefit package. Excellent opportunity for rapid practice growth. Reply Box 138, c/o *OHIO Medicine,* 600 South High Street, Columbus, OH 43215.

FAMILY PRACTITIONER, Orthopedist, Obstetrician/Gynecologist, Psychiatrist needed. 249-bed progressive community hospital. 3-year JCAH approval. Guarantee. Benefits. Close to America's #1 most livable city. Excellent educational, cultural advantages. Send CV or call (216) 385-7200. Reply Box 146, c/o *OHIO Medicine,* 600 S. High Street, Columbus, OH 43215.

HEALTH CARE PERSONNEL CONSULTING, INC., A DIVISION OF THE HEALTH CARE GROUP, specializes in valuation and sales. We have practices currently available in the following specialty areas: **Allergy, Dermatology, Family Practice, Internal Medicine, Ophthalmology, Pediatrics, Psychiatry, Psychology, Radiology and Urgent Care.** For more information regarding selling or buying a medical practice, contact our brokerage division at The Health Care Group, 400 GSB Bldg., Bala Cynwyd, PA 19004 or call (215) 667-8630.

IMMEDIATE POSITION AVAILABLE — Multispecialty Northeast Ohio Group seeking BC/BE primary care physicians: Family Practice, Internal Medicine, Pediatrics and OB/GYN. Guaranteed salary with opportunity for ownership. Excellent benefits. Reply to: *OHIO Medicine,* Box 135, 600 South High Street, Columbus, OH 43215.

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Internist needed for established private practice. Excellent general medicine practice with growing occupational medicine component. Immediate opening. Negotiable salary plus incentive participation. Complete benefit program. Partnership availability. Contact: Occupational Medical Services, Suite 107, 480 South Cleveland Ave., Westerville, OH 43081. (614) 898-5510.

INTERNIST (BE/BC) with or without subspecialty to join rapidly approaching hospital-sponsored primary care physician group. Southwest Ohio location. Progressive philosophy, comprehensive salary and benefit package. Reply with CV to Reply Box 143, c/o *OHIO Medicine,* 600 South High Street, Columbus, OH 43215.

LOCUM TENENS positions available throughout the country in all specialties. Work one to 52 weeks while you travel (expenses paid) and enjoy an excellent guaranteed income. Malpractice insurance, housing & transportation provided. Contact: LOCUM Medical Group, 30100 Chagrin Blvd., Cleveland, OH 44124 or call (216) 464-2125.

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OB/GYN NEEDED: to join group practice in northwestern Ohio. Practice located in nice area of town. Hospital affiliation with level II OB Department and other attractive facility features. Competitive beginning salary with malpractice and health insurance included. Reply Box 139, c/o *OHIO Medicine,* 600 South High Street, Columbus, OH 43215.

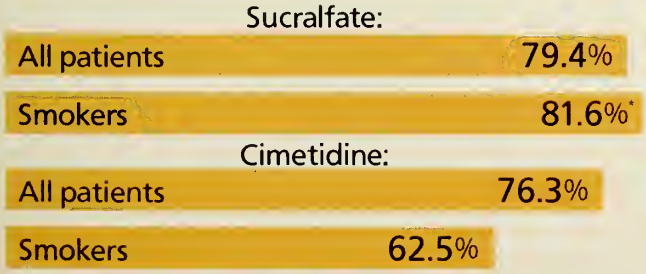
Ulcer therapy that won't yield, even to smoking



What do you do for duodenal ulcer patients who should stop smoking, but won't? Both cimetidine[1] and ranitidine[2] have been shown less effective in smokers than nonsmokers.

Choose CARAFATE® (sucralfate/Marion). Two recent studies show Carafate to be as effective in smokers as nonsmokers.[3,4] A difference further illustrated in a 283-patient study comparing sucralfate to cimetidine[5]:

Ulcer healing rates:
(at four weeks of therapy)[5]



*Significantly greater than cimetidine smoker group ($P<.05$).

Carafate has a unique, nonsystemic mode of action that enhances the body's own ulcer healing ability and protects the damaged mucosa from further injury.

When your ulcer patient is a smoker, prescribe the ulcer medication that won't go up in smoke: safe, nonsystemic Carafate.

Nothing works like

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Please see adjoining page for references and brief summary of prescribing information.

1594H7

CARAFATE®
(sucralfate)

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:
1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P: *Am J Med* 79(suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987.

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Opportunity available to physician in our community. Firelands Community Hospital is a new 273 bed facility located midway between Toledo and Cleveland on Lake Erie. Primary service area population is 80,000.* Send CV to: Firelands Community Hospital, 1101 Decatur Street, Sandusky, OH 44870 or call (419) 626-7721. (*All support services available)

OB/GYN — Rapidly growing solo practice in Cleveland needs physician for expansion. Will consider employment (malpractice insurance included) with eventual partnership opportunity. Send CV to Box 152, c/o OHIO Medicine, 600 South High Street, Columbus, OH 43215.

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Opportunity to work with a team of psychiatrists, nurses, social workers and therapists providing inpatient treatment for the 71-bed Acute Care Center of a large, not-for-profit comprehensive community mental health center. Will participate in all phases of client diagnosis and treatment in this progressive short-term program. Opportunities for professional development and research at nearby Ohio State University. Competitive salary and fringe benefit package. Submit resume to: Netcare Corporation, Personnel Department, 199 South Central Avenue, Columbus, OH 43223, Equal Opportunity Employer.

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Dual action — for peace between brain and bowel. Because of possible CNS effects, caution patients about engaging in activities requiring complete mental alertness. Specify Adjunctive

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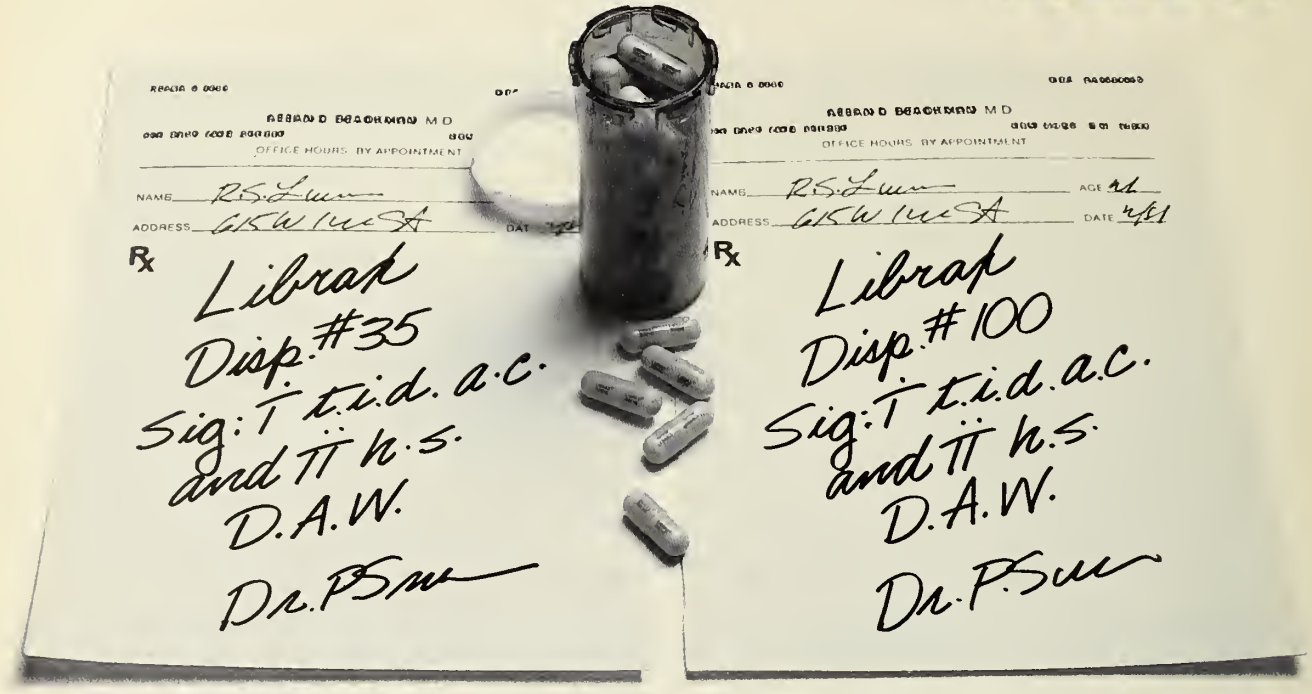
Each capsule contains 5 mg chlordiazepoxide HCl
and 2.5 mg clidinium bromide

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and the irritable bowel syndrome.

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Specify
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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/ Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Sex	☐ M ☐ F	☐ M ☐ F
Smoked cigarettes last 12 months	☐ yes ☐ no	☐ yes ☐ no
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WANTED: Internal Medicine Physician, Board Certified or eligible. Ohio licensed. To join established private practice or start independent practice with hospital assistance, in Northeast Ohio. Please reply Box 151, c/o OHIO Medicine, 600 South High Street, Columbus, OH 43215.

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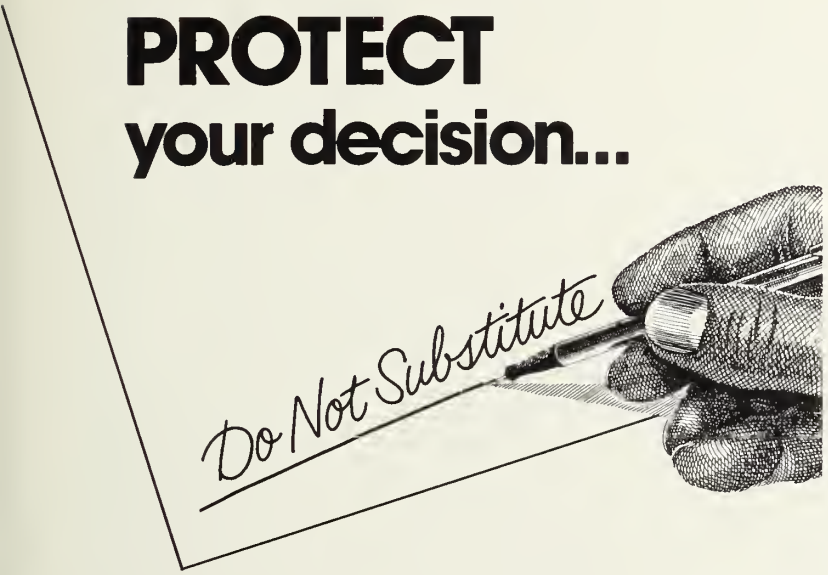
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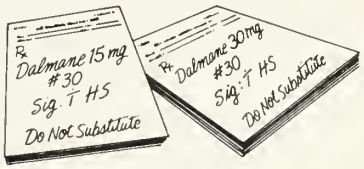
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sleep that satisfies

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References: **1.** Zimmerman AM. *Curr Ther Res 13* 18-22, Jan 1971 **2.** Amrein R, *et al. Drugs Exp Clin Res 9* (1) 85-99, 1983 **3.** Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21* 355-361, Mar 1977



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precaution: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

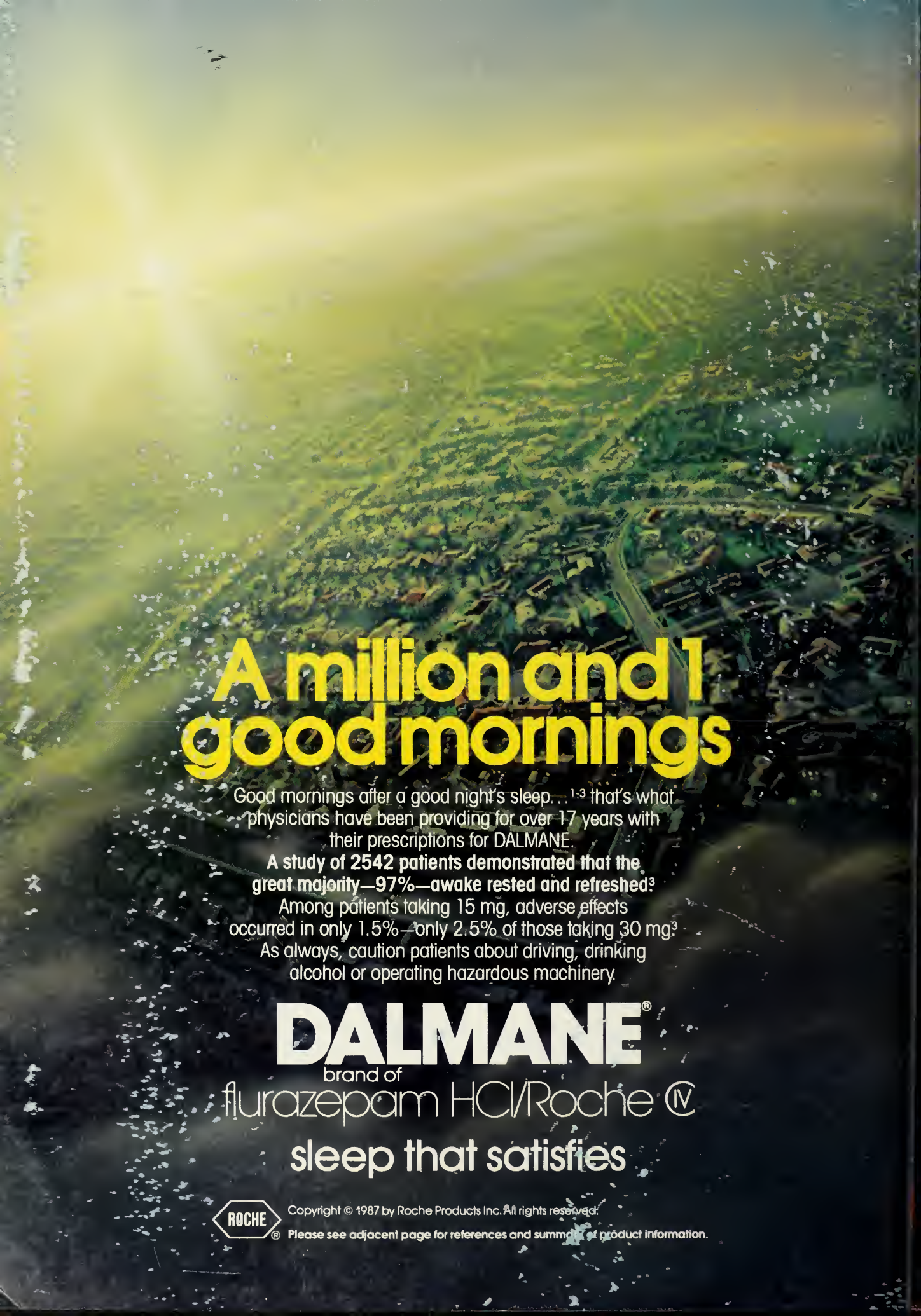
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients.
Elderly or debilitated patients: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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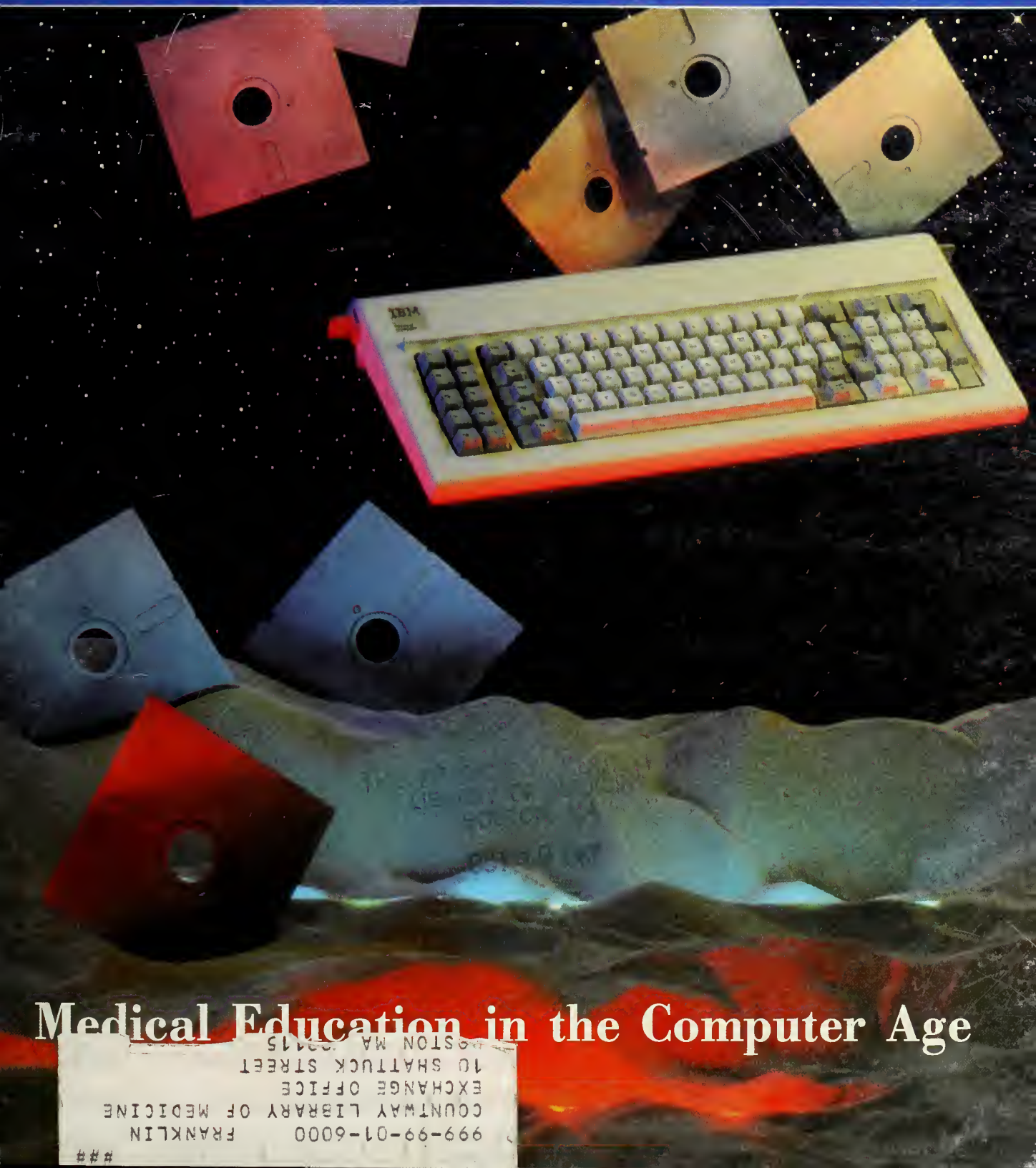
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JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 83, NO. 10 OCTOBER 1987



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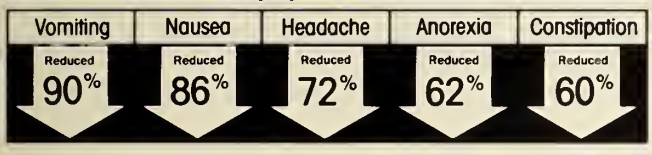
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Published monthly under the direction of The Council for and by members of OHIO Medicine, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1987 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

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Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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FROM THE EDITOR



Medical Education — Our Second Try . . .

This month, we really *are* featuring the future of medical education in Ohio, as well as various related topics. Although we intended to cover the subject in-depth last month, legislative activities proved too important to ignore, so we aborted our plans and scheduled the articles for October, instead.

Now, there are *two* ways to look at the future of medical education. First, there is the view of the faculty and those who plan the curriculum — then, there is the view of the students themselves. We have included articles representing both points of view in this issue — and we think you'll enjoy the comparisons and contrasts in thinking. Special thanks to Cindy Smith, a second-year medical student at Wright State University College of Medicine, who interviewed several medical students and prepared an article for us, based on their comments.

Related articles in this issue deal with two innovative ways the Medical College of Ohio has devised for dealing with medical school stress; and Susan Porter, a former associate editor of *OHIO Medicine,* provides us with a look at "Continuing Medical Education Is It Worth It?"

Also in this issue . . .

• Look for the start of a brand-new column, "Specialty Update," which will be written each month by a different author — selected by his or her specialty society to update you on "hot" topics and the latest news and developments occurring in that special field.

• Don't miss the profile of Ronald Fletcher, MD, the new — and approachable — Director of the Ohio Department of Health.

• Thomas Leech, MD, OSMA's new Membership Chairman presents his membership goals for the year ahead in this month's "Focus on Membership" column and, finally,

• Next month be sure to read about the experiences encountered in Afghanistan by Henry Hood, MD, a Lancaster orthopedic surgeon in our "Out of Practice" column.

And, *OHIO Medicine* takes you to market — with a special issue on physician marketing. Don't miss it!

Karen S. Edwards

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USPS 405-200

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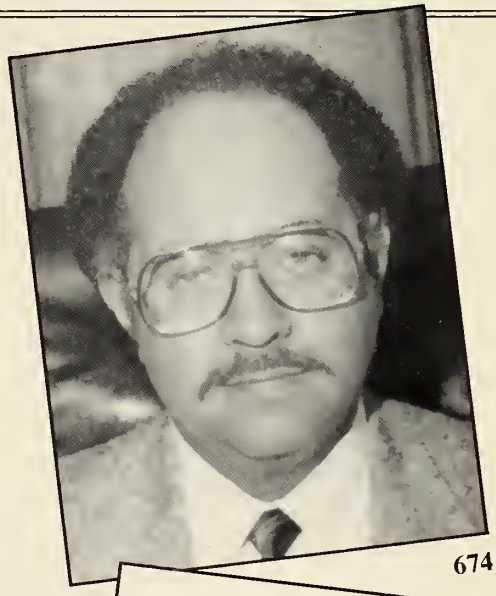
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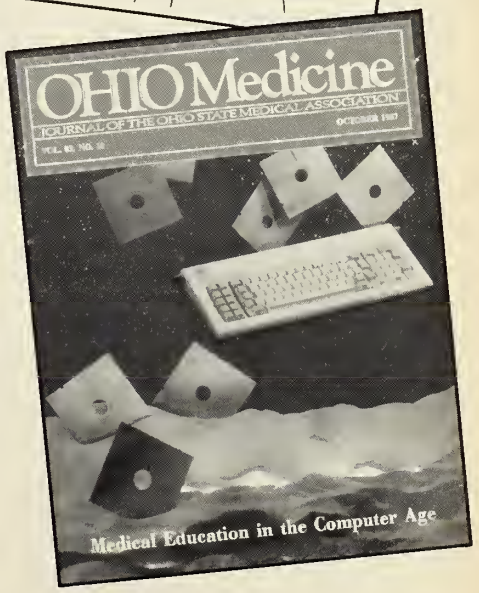
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Ohio Supreme Court Ruling Demands Physicians Take Charge for a Change

By D. Ross Irons, MD

In my address to the House of Delegates at the OSMA Annual Meeting and previously in this column I stated that organized medicine's struggle on behalf of our patients seems shrouded with adversity. Our health care delivery system is at a most critical point and I view this as an opportunity and a challenge for organized medicine as well as individual physicians, to be a positive factor in shaping Ohio's future in health care. "Taking charge for a change" is the key phrase for the OSMA and individual physicians who share a concern for the direction of the health care system in Ohio and its effect on patient care for the future.

The necessity for a positive proactive program and attitude on the part of OSMA and each and every physician has never been greater as evidenced by two recent rulings by the Ohio Supreme Court. On August 12th, the Ohio Supreme Court issued an opinion striking down the 1975 Ohio statute that required medical malpractice suits to be filed within four years after the alleged malpractice occurs. In a related decision rendered by the Court, the Court ruled that a patient has one year to sue after an alleged injury was or should have been discovered *or* one year after the patient-physician relationship ends, whichever is later. These decisions will not only have serious implications for doctors, but it will also have a devastating impact on all Ohioans.

In *Hardy vs. VerMuelen,* four of the seven Justices stated that it was unconstitutional in Ohio to establish a limitation on a patient's ability to file a lawsuit in an alleged case of medical malpractice. **The result of the Court's amazing decision is that if a doctor operates on someone tomorrow, that patient may have the right — for the rest of his life — to claim he was injured and sue for malpractice.** The decision will have serious consequences with regard to the affordability and availability of medical liability insurance and the affordability and availability of needed health care services to the citizens of Ohio.

The Ohio Supreme Court ruling on the 1975 statute comes at a time when the OSMA had successfully achieved the enactment of House Bill 327, the professional liability tort reform legislation. One of the major elements of House Bill 327 was to reaffirm the Legislature's position that a four year limit to file a medical malpractice claim was sound public policy. House Bill 327 was approved by the Legislature overwhelmingly and signed into law by Governor Celeste. The new law becomes effective October 20, 1987. The passage of House Bill 327 was the result of a tremendous effort by OSMA, individual physicians and auxilians to communicate our concerns to legislators.

However, the Supreme Court decision not only works to undermine the effectiveness of this new legislation, it also diminishes the Ohio Legislature's ability to address a vital issue. Two of the three Supreme Court Justices who disagreed with the majority opinion made some very cogent arguments against their four colleagues who supported an unlimited statute of limitations. These learned Justices of the Supreme Court clearly state our position with regard to this horrible ruling. **Justice Craig Wright wrote: "Without question today's holding creates a constitutional dilemma of severe proportions. The Court has informed the General Assembly it**

continued on next page

has no power to meet what it perceives as an epidemic crisis with responsive legislation." He went on to say that "because the majority (of Justices) disagree with the time constraints under Revised Code 2305.11 (B), (1975 medical malpractice statutes) it has, **under the guise of judicial interpretation, abrogated the function of the General Assembly and the electorate by amending the Constitution by judicial fiat." Justice Wright also stated that the majority opinion is based upon "sheer legal fiction."** He concluded his dissenting opinion by stating: "The present predicament that the medical profession and health care facilities have in obtaining malpractice insurance at a reasonable cost will rapidly spread to other professions."

Justice Robert Holmes in his dissenting opinion stated: "The public policy of the state had been expressed by the General Assembly as it related to the need for a statute of repose in medical malpractice actions and had resulted in enactment of Revised Code 2305.11 (B). This act of the legislative body of Ohio was carried out after a specific pronouncement of a medical malpractice crisis in this state, and upon a multitude of legislative hearings declaring this to be the public policy in Ohio. **This court, in determining that such legislation is unconstitutional, not only carries out a needless task, but it set itself (Ohio Supreme Court) apart as a super legislative body usurping the very constitutional prerogatives of the General Assembly."**

What type of proactive response should OSMA and the physicians of Ohio make to respond to this terrible decision that the Ohio Supreme Court Justices have made without regard to its broad impact on physicians, health care facilities and ultimately the health and welfare of the citizens of Ohio? **The following are a number of aggressive activities OSMA is implementing with the assistance of physicians and patients to confront the crisis in health care the Supreme Court has foisted upon the State of Ohio.**

1) **Legal activities** — The OSMA is committed to exhausting every avenue available to have this case reconsidered by the Ohio Supreme Court and if necessary take the case all the way to the United States Supreme Court.
2) **Legislative action** — In 1975 the Ohio General Assembly enacted the four-year statute of limitations and this year in House Bill 327 the Legislature reaffirmed their sound public policy decision. The OSMA has begun discussions with legislative leaders regarding future legislative initiatives to ensure that medial liability insurance is both affordable and available. We will make every effort to limit the effect of the Ohio Supreme Court ruling on the health care system in Ohio that serves the legislators constituents and our patients. Issues such as an overall cap on all damage awards or a state funded compensation plan for medical liability awards are two areas that could provide relief from this bad Ohio Supreme Court decision.

The U.S. Department of Health and Human Services had just issued a major report on medical liability reform which contains a number of recommended changes in tort law for medical liability cases. The report noted that American physicians professional liability premiums rose 81% between 1982 and 1985. **HHS Secretary Otis Bowen, MD states that if tort reform in medical professional liability is not achieved "the net impact of all this may mean that people will have less access to necessary medical care."**

The OSMA has successfully enacted some of the recommendations of the HHS report such as periodic payments, pretrial screening, caps on non-economic damages and alternative dispute resolution mechanisms. The HHS report does recommend shortened statutes of limitations which most all states have enacted despite the Ohio Supreme Court's opinion.

I can assure you that the OSMA will actively seek legislative relief. Together we have achieved some positive results in the passage of House Bill 327 and we must now fight to seek increased legislative action in an attempt to negate the impact of the Ohio Supreme Court.

3) **Public awareness** — The OSMA will use every available resource to make certain the public is educated regarding the impact of the Supreme Court ruling. In the spring of this year the OSMA produced a patient education brochure on the need for House Bill 327, *The Malpractice crisis: everyone's Paying the Price,* which was provided free-of-charge to Ohio physicians. In a two month period nearly 100,000 copies of this brochure were distributed to patients statewide, encouraging them to write their legislators in support of the bill. I firmly believe this support was crucial in our success at the Legislature. **Now we must educate the public regarding the Supreme Court decision and its impact on the cost and delivery of health care. We must not only reach our patients, we must reach into the general community and educate everyone regarding the seriousness of this situation.** This will involve working with the news media, public speaking and individual contact by physicians and auxilians. Working together, we must let everyone know: **This is not just medicine's problem; it's everyone's problem.**
4) **Coalitions** — Legal experts are predicting that the logic of the

continued on page 706

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of OHIO Medicine *or the Ohio State Medical Association.*

Resurgence of Rheumatic Fever

By Don M. Hosier, MD

While acute rheumatic fever remains a major cause of death in school age children in many developing countries in the world, the prevalence and severity of the disease in the United States has been on a decline since the beginning of this century and precipitously so in the past 20 years. The reason for this decline remains an enigma.

While during the past 10 years there have been only two to three relatively mild cases of rheumatic fever seen at the Columbus Children's Hospital per year, since June 1985, 38 patients have been seen and diagnosed as having acute rheumatic fever. They have come primarily from central and southeastern Ohio. Twenty of the 38 patients had a pharyngitis and eight reported some type of upper respiratory infection prior to the onset of rheumatic fever symptoms. While a positive throat culture for group A hemolytic streptococcus was obtained in only 10 patients, all but two patients, both of whom had chorea, had evidence of a previous streptococcic infection by streptococcal antibody titers. Twenty-three of these 38 patients (62%) had migratory polyarthritis, six erythema marginata (16%) and seven chorea (19%).

The severity of the disease was seen by the number of children who had carditis: 19 (51%). Of those, 14 had mitral regurgitation and five had both aortic and mitral valve incompetence. Five of the 19 were in cardiac failure when first seen. One patient, a 16-year-old-boy, died approximately one month following the onset of symptoms; post mortem findings showed aortic, mitral and tricuspid valve involvement with probable rheumatic pneumonia.

Outbreaks of rheumatic fever occurring throughout the United States during the past two years are being reported. Why these outbreaks are occurring is not presently known. Has there been an increase in the incidence of streptococcal infections?

Is there a change in the virulence of the rheumatogenic serotypes? Has a possible unrecognized cofactor, such as a virus which enhances the rheumatogenic properties of the streptococcus, been introduced or reintroduced into this country? Answers to these questions must be sought.

One additional factor should be considered. Have we as physicians become somewhat complacent in our search for streptococcal infections or in the treatment since rheumatic fever has been seen so infrequently in the past two decades? Group A hemolytic streptococcus remains extremely sensitive to penicillin, but resistance of the organism to tetracycline and, to a lesser extent, erythromycin and lincomycin have been reported.

In view of the apparent resurgence of this potentially debilitating and lethal disease, it behooves all physicians treating children to become increasingly diligent in the search for and treatment of group A hemolytic streptococcus infection.

Have we as physicians become somewhat complacent in our search since rheumatic fever has been seen so infrequently in the past two decades?

Don M. Hosier, MD, is the Director of the Division of Cardiology, Children's Hospital, Columbus.

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OHIO MEDI-SCENE

Medical golfers tournament . . . Ohio health care . . . Medicaid tips . . . clinic happenings . . . OSMA's new publication . . . team physicians honored . . . student-student update . . . student research colloquium . . .

Medical Golfers Association tournament

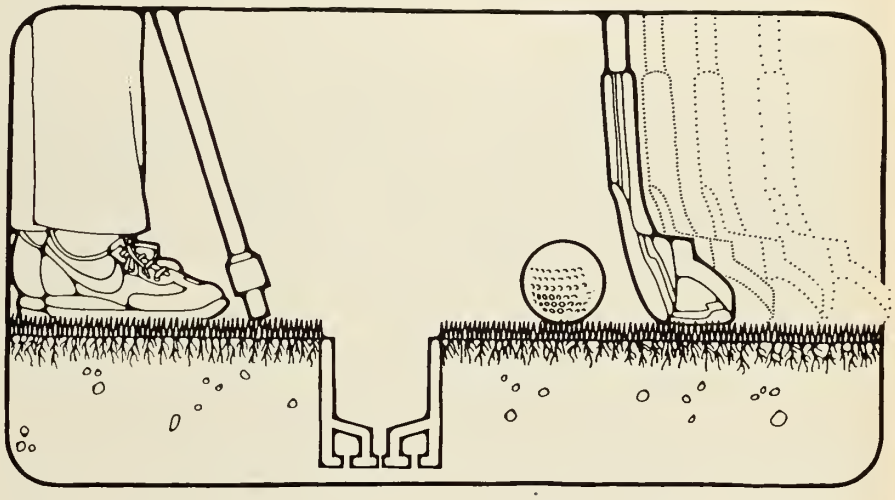
Grant Morrow, III, MD, a specialist in pediatrics-neonatology from Columbus, won the low gross championship in the 62nd Ohio State Medical Golfers Association Tournament on Friday, June 19, 1987 at the Country Club of Ashland, Ashland, Ohio.

A record 145 physicians and honorary OSMGA members participated in the event.

Dr. Morrow shot a sizzling one-under-par 71 to earn an inscription on the Richard P. Bell, MD Trophy.

B.D. Auchard, MD, a Mansfield orthopedic surgeon, and Charles G. Adams, MD, a family physician from Vermilion, tied for the low net championship with 70s. This marked the second consecutive year that Dr. Adams, Eleventh District Councilor for OSMA, tied for the low net honors. The names of the co-champions will be inscribed on the Dr. Ray Stephens Memorial Trophy.

Winner of the Dr. Carm Shamess Memorial Award for Most Improved Golfer, Scratch, 1986 to 1987, was P.B. Bhat, MD, a Mansfield surgeon. Dr. Bhat shaved 23 strokes from his 1986 score. David G. Monjot, MD, a specialist in internal medicine-pediatrics from Springfield, reduced his net score by nine strokes from 1986 to earn the Dr. Carm Shamess Memorial Award for Most Improved Golfer, Net, 1986 to 1987.



In special events competition, Dr. Morrow won honors for closest to the pin on No. 6. Thomas E. Dunaway, MD of Springfield, an OB-GYN specialist, hit the longest drive in the fairway on No. 12.

Winners in age flights were as follows:

Low Gross, Age 39 and Under — James J. Wysor, MD (second consecutive year), Sandusky (78)

Low Net, Age 39 and Under — David G. Monjot, MD, Springfield, and Kyee Y. Koh, MD, Mansfield (70)

Low Gross, Age 49 and Under — James E. Bagenstose, MD, Lima (80)

Low Net, Age 49 and Under — Robert N. Clark, MD, Columbus (70)

Low Gross, Age 59 and Under — Judson S. Millhon, MD, Columbus (78)

Low Net, Age 59 and Under — William M. Emery, MD, Ashland; James F. Gorman, MD, Toledo, and Anthony C. Nassif, MD, Cleveland (70)

Low Gross, Age 69 and Under — Edwin R. Zartman, MD, Columbus (81)

Low Net, Age 69 and Under —

continued on next page

OHIO MEDI-SCENE

Medical Golfers tournament . . . *continued*

Donal R. Ross, MD, Bay Village (70)
Low Gross, Age 70 and Over — Albert H. Voegele, MD, Mansfield (91)
Low Net, Age 70 and Over — George O. Kress, MD, Worthington (75)

During the awards banquet, OSMGA President Richard B. Belt, MD paid tribute to host physician William M. Emery of Ashland for his efforts in bringing the 1987 event to the Country Club of Ashland.

Dr. Belt also recognized Club Manager David D. Mason and Golf Professional Dan Priest for their outstanding efforts in making the tournament a success.

OSMA President D. Ross Irons, MD of Bellevue, who competed in the tournament, and Eleventh District Councilor Charles G. Adams of Bellevue, gave brief remarks.

Dr. Belt gave special recognition to several wives of Ashland County Medical Society members, as well as President Irons' wife, Becky, for outstanding service in registering the record number of golfers. Volunteers from Ashland included Karen Emery, Debbie Adkins, Candice Barr, Adrienne Lee, Jan Shin, Charmaine Stencel, and Peggy Yoder.

Serving as sponsors for the 1987 OSMGA Tournament were Caldwell & Bloor Medical Supplies of Mansfield, Immke Circle Leasing (represented by Brian Blake), Physicians Insurance Company of Ohio (represented by William M. Wells, MD and John Vance), Scioto Professional Benefits Agency (represented by Jim Grant and Don Albert), *Ohio Golfer Magazine,* and Wyeth Laboratories (represented by Gary Anania).

The record attendance included 15 physicians from the Portage County Medical Society and staff of Robinson Memorial Hospital in Ravenna playing in the event *for the first time.* Nineteen physicians from the Richland County Medical Society, 15 from the Academy of Medicine of Columbus & Franklin County, and 10 from the Clark County Medical Society also led the attendance list.

President Belt announced that the 1988 OSMGA Tournament will be played on Friday, June 24, 1988 at Marion Country Club, Marion, Ohio. — *Robert Clinger*

Ohio health care gets high marks in quality, but Ohioans worry about costs

While Ohioans are, by and large, pleased with the quality of medical care they are receiving, they are concerned with how much that care costs.

The results of an Ohio Poll, conducted last year by the Institute for Policy Research at the University of Cincinnati, show that 85% of those responding to the survey were "fairly well satisfied" with the medical care they receive — and 90% were just as happy about the availability of that care (only 6% indicated no satisfaction with their medical care, and 4% were dissatisfied with availability of care).

But just because Ohioans are satisfied with the level of medical care in this state doesn't mean they're happy with the price tag that comes along with it. Ohio Poll shows that only 7% of those who responded consider health care costs to be reasonable, while almost 30% found such costs to be unreasonable (43% opted for a "somewhat unreasonable" position).

Perhaps a better view of who is happy (and who isn't) with Ohio's health care can be obtained by breaking the respondents into different demographic groups. Black respondents, for example, proved to be more dissatisfied with the quality of their medical care than were white respondents (32% versus 13%) and blue collar workers were more dissatisfied than white collar workers.

Ohioans with less education and those with lower family incomes were more likely to consider the costs of medical care to be unreasonable.

The relatively small differences among Ohioans as a function of demographic factors, however, underscores the success that the health care industry and the public sector have had in providing all types of Ohioans with access to high quality medical care. Yet, while access to and the quality of medical care do not appear to represent problems — the public is still sensitive to the costs of that care. — *Karen S. Edwards*

Medicaid tips

The Ohio Department of Human Services makes changes in the drug formulary quarterly. Presently, the scheduled changes for the updates are February 1, May 1, August 1 and November 1.

Most of the additions and the deletions are based on recommendations presented by the Pharmacy and Therapeutics Committee. The Committee is comprised of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Walterbaugh, RN; and Robert P. Reid, RPh, Chairman.

For your information the following changes will appear in the October 29, 1987 update.

Addition to expand or clarify coverage include: Aminophyllin IM 500mg/20ml; Amoxicillin drops 30ml; AVC Cream, Supps; Azactam; Cleocin T Gel; Clorazepate; Dallergy JR; Desipramine; Diazapam Oral Soln; Enkaid; Esgic/Codeine; Estrogenic AQ Inj, 2mg/ml; Femstat Vag 3's; Furosemide Oral Soln; Glucagon Kit; Inderal LA 60mg; Indomethacin Oral Susp; Lactrase; Lamprene; Leucovorin 15mg; Levothyroxine; Naprosyn Susp; Nitrocene Patches; Novolin R Cartridges; Oxazepam; Pramosone Lotion 2½%; Principen/ Probenecid caps; Propranolol Oral Soln; Thiothixene.

Deletions due to product no longer available include: Alphaderm; Aminosalicylic Acid; Ampicillin N Inj 250mg, 1gm; Ampicillin/Probenecid caps; Aminophyllin 500mg/10ml, 500mg/50ml; Chromagen Inj; Colchicine 1/120gr; Corticaine Supp; Danthron; Diasone; many Diethylstilbestrols; Digitalis 100mg; Docusate/Danthron; Hyperopto; Imferon 5ml; Kemadrin 2mg; Koromex; Levodopa; Percogesic/Codeine; Psoranide; Purodigin; Quide; SK-Penicillin; Suprol; Terramycin Syrup; Triclos; Tri-Cone Plus; Valisone Aerosol.

Deletions due to not being cost-effective compared to other formulary trade name equivalents include: Ergomar; Tridesilon; Zaroxylon.

Deletions due to the creation of a Maximum Allowable Cost (MAC) include: Anspor; Apresazide; Bancap HC; Co-Gesic; Esgic; Etrafon; Triavil; Velosef; Hydrocet; Hy-Phen; Valium Inj; Vicodin; Zydone.

Deletions due to **RECENT FEDERAL (NOT STATE) REGULATIONS** concerning upper-ceiling reimbursement include: A/T/S; Actifed/Codeine; AK-Chlor; Ak-Con; AK-NeoCort O.S.; AK-Sporin O.O, O.S; AK-Sporin HC Otics; Aknemycin Soln; Albalon; Aldactazide 25/25; Aldactone 25mg; Atromid-S; Bactrim Ped Susp; Bactrim Susp; Bleph-10 O.S.; Cafergot Tab; Calan 80mg,. 120mg; Catapres 0.1mg, 0.2mg, 0.3mg; Cetamide 0.0.; Chloromycetin 0.0., O.S.; Chloroptic O.S.; Compazine Tab 5mg, 10 mg, 25mg; Cortisporin Otic Soln, Susp; Demerol 50mg, 100mg; Depakene 250mg; Desyrel 50mg, 100mg; Dexacidin 0.0, O.S.; Diabinese 100mg, 250mg; Dilantin 100mg; Dycill 250mg, 500mg; EES 400 Tab, 200mg/5ml, 400mg/5ml; Elixophyllin 80mg/15ml; E-Mycin 250 mg; E-Mycin E 200mg/5 ml, 400mg/5ml; Eryderm Soln; Erymax Soln; Eryped 400mg/5ml; Erytab 250mg; Erythromycin Base 250mg Abbott; Eskalith 300mg; Exsel Lotion; Garamycin 0.0., O.S.; Genoptic 0.0, O.S.; Gentacidin 0.0., O.S.; Hytone Lotion 1%, Oint 1%, 2.5%; Ilosone 125mg/5ml, 250mg/5ml; Ilotycin 0.0, 250mg; Inderal 10mg, 20mg, 40mg, 60mg, 80mg; Inderide 40/25; Isoptin 80mg, 120mg; Kwell Lotion, Shampoo; Lasix 20mg, 40mg, 80mg; Lidex Cream 0.05%; Lidex E Cream 0.05%.

To keep you informed of changes in the Medicaid Drug Formulary your OSMA representative to the P & T Committee, Dr. Janet Bixel, will keep you informed. — *Robert P. Reid, RPh, Chairman; Janet Bixel, MD, Advisor*



Institute for Voice Analysis, St. Elizabeth Hospital, Dayton.

Clinic happenings . . .

A quick perusal around the state reveals a steady wave of clinic resources — from diagnostic testing centers and travel clinics to women's health developments and clinics on wheels. Here is a sampling of the variety available to Ohio physicians and patients:

Institute for Voice Analysis and Rehabilitation

A new series of analyzing mechanisms for voice disorders is in gear at St. Elizabeth Medical Center's Institute for Voice Analysis in Dayton.

"Traditionally, voice evaluation has depended solely on the skills of the examiner to listen to the patient's voice and to make a judgment regarding its quality," says Joe Stemple, PhD, a speech pathologist and coordinator of the institute.

The new-and-improved testing method for disorders such as polyps, nodules and potential

continued on next page

OHIO MEDI-SCENE

Clinic happenings . . . *continued*

cancers takes several leaps beyond the typical laryngeal mirror exam and voice evaluation, says Stemple.

Requiring just 45 minutes on an outpatient basis, Phonatory Function Testing (PFT) elevates voice disorder diagnosis from the subjective to the objective realm, he continues. One aspect of PFT is an acoustical analysis of voice properties, such as pitch, loudness and hoarseness, on specially programmed microcomputers; another aspect, aerodynamic testing, computes the amount of oxygen in the lungs and how the oxygen moves through the vocal cords.

PFT also ushers the new age of VCR and MTV into the examining room with the arrival of videostroboscopy, a technique which videotapes the movement of the vocal cords. For the first time, researchers can observe the function of the vocal cords in slow motion and record their appearance for future use.

"The new stroboscopic techniques enable us to see movement disorders, the presence of gaps or chinks between cords, as well as scarring or stiffness, which has opened up a whole new area of diagnosis," Dr. Stemple explains.

Patients can witness the condition of their vocal cords on screen, and may be more apt to become a partner in their own rehabilitative process, he adds.

Because PFT provides more definitive information than in the past — thereby saving time and money and diminishing the need for exploratory surgery — Dr. Stemple predicts the new diagnostic testing will become routine by the early 1990s.

For more information, contact the Voice Institute at (513) 229-6081.

The Black Lung Clinic

The Lancaster-Fairfield Community Hospital's Black Lung Clinic has opened its doors to educate and provide services to Southeast and Central Ohio coal miners with black lung disease.

The clinic recently received an Ohio Department of Health grant to aid an estimated 10,000 black lung patients who reside in the 12-county region, including Fairfield, Franklin, Gallia, Hocking, Jackson, Lawrence, Meigs, Pickaway, Pike, Ross, Scioto, and Vinton counties.

While patients with black lung — or pneumoconiosis pulmonary disease — will never regain normal functioning of their lungs, they may learn to modify some of the disease's symptoms — e.g., breathing difficulties, low oxygen levels — with breathing exercises, medication and diet changes.

Those interested in more information should call the hospital's Cardiopulmonary Department at (614) 687-8170. The clinic will be taking referrals from personal physicians.

Balance Disorders Clinic

At times, patients who complain of vague symptoms such as dizziness or headaches may have to go through many different specialists before finding the right one.

That's why the goal of the University of Cincinnati Medical Center's Balance Disorders Clinic is to "stop the revolving door philosophy," explains Myles L. Pensak, MD, Director of the Division of Otology/Neurology.

The success of the clinic is hinged on a multidisciplinary approach to balance disorder symptoms, by having a variety of specialists on call, including neurologists, neurosurgeons, internists, rehabilitative therapists and physiatrists.

Patients will undergo initial screening, evaluation and balance testing. Then, clinic physicians will go "on line" with a new diagnostic computer system, platform posturography.

"Platform posturography enables us to test the three main areas of balance testing — visual, inner ear and joint position sense — individually and in concert," Dr. Pensak explains. The computerized testing offers more information than was accessible before, he adds.

Dr. Pensak is optimistic that the testing will be maximally effective in time, cost and number of visits: "The sooner the patients can be diagnosed and taken care of, the sooner they can resume their normal routines."

For more information, call the Balance Disorders Clinic at (513) 872-7660.

Travelers' Clinic

If one of your patients is planning a trip halfway around the globe — and wants to know whether to drink the water once there — you may want to refer him or her to a travelers' clinic like the one in operation at

University Hospitals in Cleveland.

The Travelers' Clinic can recommend not only whether to drink the water in a certain area of the world, but can also provide information about immunizations, overseas doctors and general preparations for international travel.

Some of these recommendations include carrying a travel health kit with such items as aspirin, antacid and sunburn lotion, as well as bringing along a medical history detailing specific health conditions, allergies or medications.

For more information, call (216) 844-3295. — *Deborah Athy*

OSMA Launches New Publication

Too little time and too many publications to read each month? No easy way to get the information you need because of your busy hospital routine? Well, now the Ohio State Medical Association has just the answer — *Medical Staff Bulletin.*

Medical Staff Bulletin is a new, monthly publication designed to keep hospital physicians up-to-date on OSMA news and current health care developments. It covers such topics as: the impact of health care legislation on physician's practices; changes in Medical Board requirements; how to order free patient education pamphlets and includes a monthly calendar of upcoming scientific meetings and other medical events.

In its easy-to-read poster format, *Medical Staff Bulletin* gives you the information you need in the time you have. Each month, a new issue will be posted in hospital physician lounges so you can read at your convenience. Comments and suggestions for future issues should be directed to the OSMA's Department of Communications and Physician Marketing.

Team physicians honored



Seated is Leonard M. Gaydos, MD, Tiffin. Standing from left to right are J.D. Graham, athletic director and head football coach at Newark Catholic High School, who accepted the award for Gerald A. Erhard, MD in his absence; Glenn E. East, MD, Greensburg; K.K. Solacoff, MD, Upper Sandusky; R. Gilbert Mannino, MD, Newark, and Jon H. Cooperrider, MD, Loudonville.

Six physicians have been named "Ohio Outstanding Team Physicians" by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and Ohio High School Athletic Association. The following were honored in ceremonies this summer in Canton:

Jon H. Cooperrider, MD — Loudonville High School, Loudonville, Ohio, 20 years of service

Glenn E. East, MD — Green High School, Greensburg, Ohio, 22 years of service

Gerald A. Erhard, MD — Newark Catholic High School, Newark, Ohio, over 25 years of service

Leonard M. Gaydos, MD — Tiffin Columbian High School, Tiffin, Ohio, over 25 years of service

R. Gilbert Mannino, MD — Newark Catholic High School, Newark, Ohio, over 20 years of service

K.K. Solacoff, MD — Upper Sandusky High School, Upper Sandusky, Ohio, 30 years of service

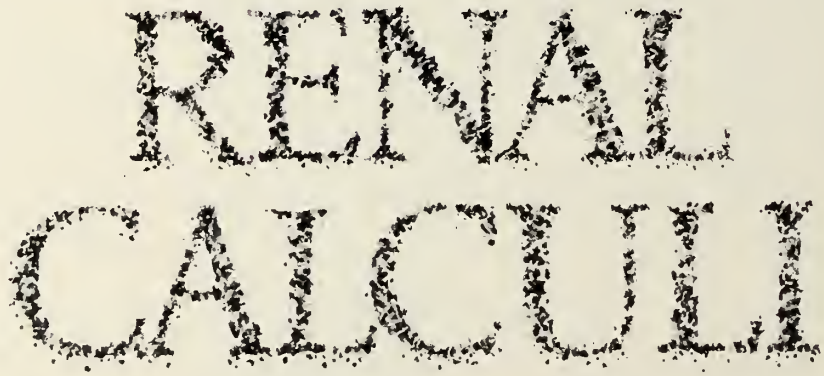
The awards were presented by Michael J. Vuksta, MD, Youngstown, chairman of the Joint Advisory Committee on Sports Medicine of OSMA, the Ohio High School Athletic Association and Ohio Athletic Trainers Association; James T. Violet, MD, Chairman, Subcommittee on Education of the Joint Advisory Committee; and Richard Armstrong, commissioner of the Ohio High School Athletic Association.

Quotes of Note

"Being sued for malpractice is one of the most severe stresses a physician ever experiences."

— Lino Covi, MD, AMA News

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We're proud to announce the introduction of Extracorporeal Shock Wave Lithotripsy as a new feature of our kidney stone treatment program. This new device makes it possible to pulverize and eliminate kidney stones without invasive surgery. Now you have the opportunity to participate in this state-of-the-art procedure at CAMC's High Tech Center here in Charleston, West Virginia.

The Lithotripter uses shock waves to bombard kidney stones into sand-like particles inside the body. The residue is then easily passed. Although the theory behind Lithotripsy is simple, the process is precise. The stone is pinpointed inside the body with fluoroscopy and shock wave firing is synchronized with the patient's heartbeat by electrocardiogram. Usually, the entire process takes about an hour.

As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

We're encouraging all area urologists to apply for privileges in Extracorporeal Shock Wave Lithotripsy. We invite you to visit CAMC and see the lithotripter in action. Come and learn about this revolutionary therapy. We will happily provide you with a brochure for your use as well as brochures for your patients.

For your brochures or other information about Lithotripsy and our kidney stone treatment program, call CAMC: in West Virginia at 1-800-654-0159; from out of state, call 304-340-7315.

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	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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The original hydrocodone analgesic.

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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
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The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. S685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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OHIO MEDI-SCENE

Student-student update

The OSMA-MSS Student-Student project sends medical students out to teach elementary through high school-age students about topics such as AIDS, drugs and alcohol and smoking. This project was featured in the September issue of **OHIO Medicine.** *The following is a brief update on the progress of the Medical Student Section's Student-Student project.*

The Student-Student project was one of two projects chosen to be featured at the national AMA-MSS meeting. A model Drugs and Alcohol presentation was made by Nick Dewan, MD (a 1987 graduate of the Medical College of Ohio at Toledo and an active MSS member) to close to one hundred interested students from across the United States. A brochure addressing how to organize and instigate a Student-Student program was given to those who attended. Richard Steinman, one of the current executive directors of the pilot program in Toledo, said that he has received several requests for more information from students who saw the presentation at the national conference.

In Ohio's medical schools the Student-Student project continues to grow. The pilot program at Medical College of Ohio at Toledo now has over one hundred trained student presenters and plans to reach over 4,000 elementary and junior high students in Northwestern Ohio this year. With the OSMA printing brochures to send out to schools and also paying the postage costs for the mailings, two other Ohio schools will begin operating Student-Student programs this year. NEOUCOM plans to launch their Student-Student program later this year. Wright State University students have been working this summer in order to have their program fully operational this fall.

Medical students are in a unique position to reach elementary through high school-age students on a variety of important health-related issues. The OSMA-MSS plans to continue to expand the Student-Student program on both the state and national levels. — *Cindy J. Smith, Wright State University School of Medicine.*

Student research colloquium announced

The Medical Student Section of the Ohio State Medical Association (OSMA-MSS) is planning the first Annual Medical Student Research Colloquium to take place February 1988 in Columbus. Students are invited to submit abstracts of completed or ongoing research which they have conducted or participated in while in medical school.

The goal of the OSMA-MSS is to give students the opportunity and experience of presenting their work, and to acknowledge the fine research which is accomplished at the student level at Ohio institutions.

The first call for two-page summary abstracts will be October 1st, the final call being January 1, 1988. A panel of faculty reviewers will select five finalists to present their research at the OSMA-MSS annual meeting. An awards ceremony for the winners and finalists will follow the presentation.

Information regarding research submission requirements and deadlines will be forthcoming in future *OSMAgrams* and through the school MSS delegate.

Any faculty interested in becoming a member of the faculty review panel, please contact Karen Guss-King at the following address:

The Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215
Attention: Dave Torrens

Fulton Memorial Lecture

Dennis O'Leary, president of the JCAH will discuss "Future Trends in Quality of Care Evaluation" and "Credentials Verification: Old and New Issues"

October 20
7:30 AM
Riverside Methodist Hospital
Columbus, Ohio

Before stepping into his new role as Director of the Ohio Department of Health, Ronald L. Fletcher, MD (right) served as director of oncology at Greene Memorial Hospital.



Ronald L. Fletcher, MD:

A Profile of Ohio's New Health Director

By Deborah Athy

In a spacious office seven stories above Ohio's capital city, Ronald L. Fletcher, MD, could play the part of the unapproachable, ivory tower magistrate.

But within minutes he rattles that possibility by stepping out from behind his large polished desk and taking one of the chairs reserved for visitors.

This at-ease attitude must have served Dr. Fletcher well in his years practicing medicine in the Dayton/Xenia area. But at age 38, he has opted to forego his medical practice in favor of taking on the role of director of the Ohio Department of Health (ODH) — a switch which has required some reorientation.

"It's very difficult because of the relationship I developed with my patient-family," explains Dr. Fletcher, who served as director of oncology at Greene Memorial Hospital in Xenia and director of oncology/hematology with the Miami Medical Group HMP.

But the opportunity to serve as ODH director arrived at an appropriate time — an associate was in the process of joining Dr. Fletcher's medical practice; so, knowing that his patients wouldn't be left without a doctor, he felt free to make the change.

Dr. Fletcher views his new position as a challenge which, in many ways, is consistent with other efforts he has been involved with in the past, like working with ODH preventative medicine groups and chairing the Governor's Task Force on Minority Health, State of Ohio. And while the job entails a significant amount of administrative work, that's not totally foreign to someone used to running a medical office.

Ever since receiving his MD degree from Meharry Medical

"The Department of Health is not a light-colored stone building. It is, in fact, your health department, an extension of our concerns for every individual in the State of Ohio."

College in Nashville in 1974, he began developing a multidimensional approach to health issues. "I've had to wear so many hats — as a practitioner, researcher, educator, scientist — that I can now look at problems from many different aspects," says Dr. Fletcher, a clinical professor of medicine at Wright State University and former associate consultant to the Dayton Board of Education.

"The traditional director of the Department of Health was someone who had been in public health administration all his life," he says. But Dr. Fletcher says the skills and desires he developed practicing medicine will come in handy in his new role. "I want to adopt the same sort of sensitivities, concerns and feelings for the people in the state of Ohio as I have for the people of my practice."

In fact, he only half-jokingly describes himself as "Ohio's family doctor," saying he wants to practice an open-door policy during his tenure in office, in which he is accessible to physicians and the public alike.

Some Ohio newspapers have suggested that Dr. Fletcher is out to "humanize the system." According to the new director, if this means bringing into the realm of public health the attitude of the practitioner who works with the people, then it's an apt description.

"In my opinion, if we push a million pieces of paper around the Department of Health and it doesn't help someone get better, then we're not doing anything," he says. That's why one of his goals is to emphasize to Ohio health workers how their jobs impact the citizens of this state.

For example, while a plumbing inspector and an accountant for a nutritional needs program perform very different functions, each impacts the livelihood and well-being of tens of thousands of Ohioans, he explains.

"The Department of Health is not a light-colored stone building isolated in the state capital. It is, in fact, your health department, an extension of our concerns for every individual in the State of Ohio," Dr. Fletcher stresses.

It is the job of the ODH leadership, he continues, to provide the tone, consistency and visibility of the department, and to reflect an attitude of caring to the state of Ohio.

In addition, the ODH must establish a policy of working together with other organizations, such as the OSMA, says Dr. Fletcher, himself an OSMA member. "To be able to tap into an organization which has the access to so many medical professionals is extremely important," he points out.

While some organizations work along separate lines to accomplish common goals, Dr. Fletcher would like to see a strong rapport developed between ODH and OSMA. If the two organizations can concentrate their efforts, Ohio physicians could be better equipped to take a proactive rather than reactive stance to health issues, he points out.

Dr. Fletcher commends the Ohio physician population for the excellent job they're doing. "The degree of sensitivity and the degree of knowledge, the art and the science, are being well practiced in the state of Ohio," he says.

These physician qualities are of vital importance in dealing with the many challenging health issues facing Ohio, he continues. Of these health issues, AIDS is in the forefront because of the level of fear associated with it. "It is essential for the ODH to establish itself as *the* leader in AIDS education and information, and, from the standpoint of the physician-patient relationship, that the ODH assist and guide physicians by working as the reference, the informational source."

Dr. Fletcher hopes to direct the ODH into a more visible role so that the media and the general public will get "the true facts" on AIDS and other health issues. To this end, the ODH will be distributing a position paper on AIDS — to health commissioners, the media, physicians, etc. — which will outline the department's position on various AIDS issues.

The paper will identify reputable testing centers and will provide information on such things as sero surveys, false/negative readings and the ODH's position on AIDS testing — which recommends

voluntary testing with counseling, rather than mandatory testing.

One of the purposes of the AIDS paper is to counter potentially harmful information which may be disseminated by pseudo-scientific factions operating in society, Dr. Fletcher points out. "We want to offer an alternative which is more responsible and scientifically more precise."

By keeping up-to-date with the AIDS situation in Ohio, the ODH will be better equipped to gauge health programs. Indeed, he adds, "We may be able to note that Ohio is a lot better off than a lot of people suspect" — though that is not to suggest that Ohio is out of the danger zone yet.

At the same time, Dr. Fletcher emphasizes that health care professionals, as well as the public, shouldn't lose sight of a number of other pressing issues, including infant mortality, teenage pregnancy, smoking, and quality disparities in health care, to name a few.

The long-term question and an overall goal for the ODH will be how to maintain and assure quality of care for all Ohioans, he stresses. Some health care analysts have suggested that health care rationing will be a reality by 1995, "something I find intolerable," Dr. Fletcher says.

Consequently, "now is the time to start making preparations to make the system more efficient." According to Dr. Fletcher, an efficient system is hinged on a strong emphasis on preventative health. "If you keep your population healthier, then you're going to save many health care dollars."

As he points out, because there is a strong correlation between lifestyles and medical costs, preventive measures such as preventing teenage pregnancy, ensuring adequate prenatal care, and snuffing out smoking and drinking habits will pay off in the long run.

To this end, Dr. Fletcher is promoting a peer-to-peer program to discourage teenagers from lighting up. Taking the example of his three children, ages 8, 12 and 15, Dr. Fletcher says there is often a certain amount of resistance, or peer incompatibility, when an adult tells a child or a teen not to do something. But if a teenager encourages another teenager not to do something, there may be more success.

The peer-to-peer program is modeled after one Dr. Fletcher developed in Nashville, when he was completing his medical fellowship. This "very rewarding" program received a national award from the American Cancer Society and was based on a domino-effect of communication among students — from medical students to high school to junior high to grade school. This heard-it-through-the-grapevine concept is similar to the Student-to-Student program kicked off by the OSMA Medical Student Section, which involves medical students discussing a variety of health topics with high schoolers.

These kinds of educational programs are useful because they can be implemented in a variety of ways, such as discouraging alcohol use and teenage pregnancy, Dr. Fletcher explains. It's one thing for a mother and father to sit down and tell their daughter not to get pregnant; it's quite different if this advice comes from a teenage mother. "We have to use what the people utilize as their sources of information," he says.

With a full agenda of goals, challenges and issues ahead, one wonders if there is life outside of the ODH for Dr. Fletcher. Indeed there is — at his home in Dayton, where he enjoys relaxing with his family.

While Dr. Fletcher has no immediate plans to relocate to Columbus, he says he doesn't mind the 70-mile commute to and from his office. "I enjoy the countryside of Ohio . . . watching the corn grow . . . getting one's thoughts together. It's time well-spent in contemplation."

All in all, Dr. Fletcher appears to be the antithesis of the ivory tower magistrate; but that's not to say he doesn't entertain some rather lofty goals. "I want to make the Ohio Department of Health the best health department anywhere, and the people of Ohio the healthiest anywhere."

Deborah Athy is Associate Editor of **OHIO Medicine.**

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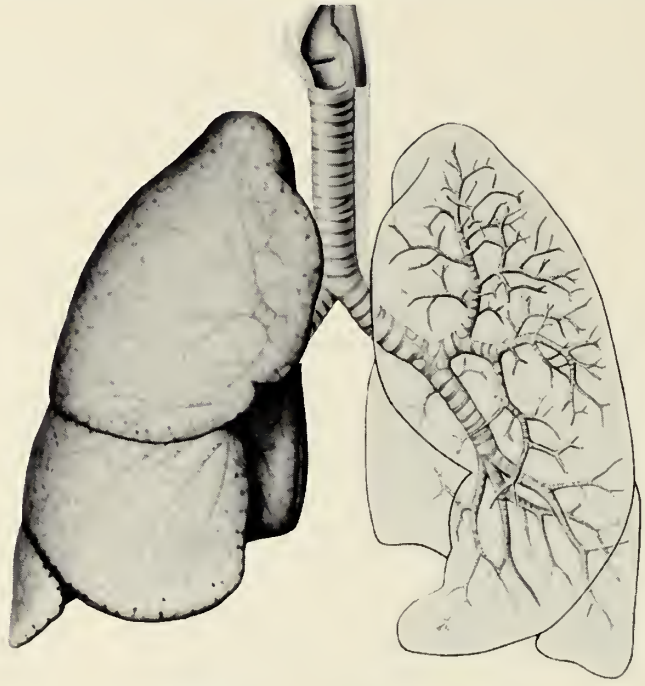
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The Future of Medical Education

Introduction

John E. Albers, MD, stood before the House of Delegates this past spring and, in one of his final appearances as OSMA President, voiced some concerns about the future of medicine.

Some of his concerns have been expressed before . . . the impact of the rapidly increasing elderly population on health-care delivery systems . . . rationing of health care . . . the cost of health care . . . and the ethical questions raised by medicine's ever-increasing, ever-improving technology.

But then, he made a statement that made many listen more closely.

"Over the past several years, the public esteem of our profession has slipped, and this is apparently being reflected in the applicant pool for medical school."

If ever there was an accurate barometer to measure the direction of medicine's future, medical school would have to be it — so it was significant when Dr. Albers mentioned that interest in medicine as a profession, and as a career, is slipping.

"Why is there a decrease in the applicant pool? Is medical education too long . . . too expensive? Is our premedical education wrong?"

The questions Dr. Albers asked the assembled delegates that warm spring evening deserve an answer, for somewhere within the responses may lie the shape and form of medicine-to-come.

To find answers to these questions, *OHIO Medicine* went to two sources — first, to the deans of Ohio's six allopathic medical schools; and then to the students themselves. Their responses will follow in two separate articles. If you're interested in the direction medicine appears to be headed — who will practice it, how these individuals are being taught, and how it will be different from today's medicine — you won't want to miss either . . .

The View from the Dean's Office

By Karen S. Edwards

In 1982, medicine was still one of the most desirable professions in the country. Over 35,000 applicants applied that year for one of the 16,467 positions available in this country's 127 medical schools. Two years later, the number of applications rose to a staggering 42,624 for an available 14,579 positions. In other words, during 1984, medical schools saw *three* applicants for every position they were trying to fill. Medicine's future couldn't have been bigger, brighter or better.

Now, however, the story has changed. Medicine is still a desirable profession, but it is no longer the *only* desirable profession, and the size of the student pool applying to today's medical schools seems to reflect that.

"It's a fact that the number of students applying to medical school has declined all over the country in the past few years," says John Hutton, MD, Dean of the University of Cincinnati's Medical School. And, he adds, Ohio is keeping up with those nationwide statistics.

"Ohio is not a growing state as far as medical students are concerned. It's not critical yet," he quickly points out, "but it could get that way."

In fact, some Ohio newspapers have already run stories about predicted doctor shortages by the year 2015 — an interesting revelation in light of the GMENAC report that promised an overpopulation of physicians by 1990.

But you can't argue with facts — the hard, statistical data that comes from the offices of the American Association of Medical Colleges (AAMSC).

According to *their* figures, the size of the 1986-87 applicant pool to medical school dropped to 31,323 applicants for 16,103 positions — less than the traditional two-candidates-per-vacancy ratio — "and the lowest this figure has ever been in history," says Charles Fentress, Director of Public Relations for AAMC.

That statement is enough to lend at least *some* credibility to those newspaper accounts — making it easier to believe that the "dime-a-dozen" doctor GMENAC predicted seven years ago might very well end up on the country's "endangered species" list 25 years later. And if that *does* happen, what will become of health care? Americans will get older . . . live longer . . . need more care . . . and who will be there to provide it?

In those terms, then, the issue of declining applicants seems a serious one, indeed.

Richard Behrman, MD, Dean at Case Western Reserve University's (CWRU's) School of Medicine says that although his medical school has not yet experienced a decline in its applicant pool, "That doesn't mean we aren't worried about it. We are making an effort to inform students about our program, and we are marketing more aggressively than we used to."

Of course, the trouble is there simply aren't as many students to market *to*.

Quantity and quality

"The number of applicants for medical school is directly influenced by how many people were born 21 years ago," says Colin Campbell, MD, Dean of the Northeastern Ohio Universities College of Medicine (NEOUCOM). "Now that the children of the 1950s Baby Boom have grown up and settled into their own careers, there is no longer a wealth of students from which to draw."

The phenomenon, of course, is not exclusive to medicine. According to the deans, *all* professions are currently experiencing a slump, but the science professions have typically had trouble attracting students, so a slump in medicine seems even more devastating than that being

experienced by the others.

Another reason for the sudden turn-around in the applicant pool, they add, is the variety of career choices available to today's student.

"It was always thought that if you went into medicine, you would have personal, as well as financial success — but now, you can do just as well as a lawyer or a businessman," says Dr. Hutton.

Of course, the flip-side of this story is that more women are choosing medicine as a career — but the white males who have traditionally entered medical school are now looking around for other careers, says Dr. Hutton.

And who can blame them, ask the deans, now that the press — and even other doctors are painting grim pictures of medicine's future?

"There is a general perception that medicine is no longer a desirable career choice," says Dr. Behrman. "What with the problems they are encountering in their own practices — malpractice, government regulation and so on — medicine as a career seems less attractive to today's practicing physician and they are getting the word out."

That includes medical families who are no longer encouraging their offspring to go into the profession, says Dr. Campbell.

"They're not actively discouraging it — but they're admitting that medicine, as a career, is not as good as it used to be," he points out.

With fewer students choosing to go into medical school, then, does it necessarily follow that those who *are* entering medicine are no longer the "brightest and the best"?

Maybe, says Dr. Campbell.

"The difference we're beginning to notice is that, while the applicants are academically skilled, they may not possess as many social skills as previous candidates have had. They are not as well-rounded."

Dr. Hutton, at the University of Cincinnati, agrees that some of the students coming into medical school lack skill in certain areas — and he points, specifically, to rusty reading and writing skills as one of the biggest problems.

"Often they have not had a strenuous reading curriculum at the undergraduate level, so when they come into medical school, where the reading is often very strenuous, they have difficulty making it through the material," he says.

He also points out that the same type of thing happens when the medical student attempts to write a patient history. They have not had much experience with writing, he claims, so, as a result, the histories are often vague and poorly-written.

"If I could change anything about the medical school curriculum," he sums up, "it would be to go back to the undergraduate level and strengthen these two areas of study."

William Sawyer, MD, Dean of the College of Medicine at Wright State University, admits that it's hard to document whether or not there has been a decline in the quality of student applicants, but he also has the general impression that medical schools are losing a "disproportionate" number of upper-grade students.

Not that such a loss is necessarily bad, though, says Frank Standaert, MD, Dean of the Medical College of Ohio (MCO) at Toledo. In fact, he looks upon the declining applicant pool as an opportunity to draw from a larger student base.

"Before this decline, we had to take those students who were making straight As, simply because you can't afford to ignore those kinds of grades," he says.

Now, with fewer straight-A students to look at, Dr. Standaert says medical schools *can* afford to look at the straight-B students — many of whom have broader-based backgrounds than those with



John Hutton, MD
Dean, University of Cincinnati Medical School.

"It was always thought that if you went into medicine, you would have personal, as well as financial success — but now, you can do just as well as a lawyer or businessman."



Richard Behrman, MD
Dean, Case Western Reserve University School of Medicine.

"We assume that students can read and write. Medical school is no place to be learning English 101."

straight-A grades.

"We prefer students who have had more broad-based training in the humanities or liberal arts," says Case Western's Dr. Behrman. "We don't necessarily want the chemistry major who has taken only science courses at the undergraduate level."

Premedical education

Which raises the issue of what subjects today's students *will* need to study at the undergraduate level to enhance their chances of admission to tomorrow's medical schools.

"I may be more open-minded than others on this subject," admits Wright State's Dr. Sawyer, "but my personal view is that we should be careful about specifying what courses students should take at the undergraduate level. There *are* bodies of knowledge that a student *needs* to be well-prepared in medical school, but there is no certain set of course experiences that will make that student a better doctor."

He points to the University of Pennsylvania which, this year, eliminated all of its requirements for medical school.

"I'm not sure that is as drastic as it sounds," Dr. Sawyer continues, adding that he would like to see course requirements at medical school replaced with a statement — "we assume you know . . ."

Yet some of today's medical schools are already making such assumptions.

"We assume that students can read and write," says Case Western's Dr. Behrman — echoing Dr. Hutton's earlier sentiments that "medical school is no place to be learning English 101."

Nor is it the place, for that matter, to be learning ethics, humanities, or social sciences, says Manuel Tzagournis, MD, Dean of the Ohio State University College of Medicine.

"Humanities and ethics can and should be taught at the (pre-medical school) level, so that, by the time a student gets to medical school, the concentration of courses can be in the area of science," he explains.

That's not to say, however, that humanities have no place in medicine at all, Dr. Tzagournis hastens to add. With medicine becoming so technological and the amount of time spent with doctors becoming more and more minimal, he believes that the humanities may actually play an *increasing* role in tomorrow's medical schools.

"The problem," says Dr. Standaert, in explaining why he agrees medical school is not the place for broad-based courses in ethics, sociology and other non-medical related subjects, "is that if you add one course, you have to give up another. It becomes a matter of priorities."

He questions whether humanities will play a larger role in tomorrow's medical schools.

"We may see a sprinkling of medical ethics and those kinds of courses included in the curriculum, but not that much. Instead, we have to teach what's *most* important."

Of course, *every* school has to wrestle with that question of what to teach, what's most important — and what's most important at the University of Cincinnati, says Dr. Hutton, is a strong science background. In fact, Dr. Hutton feels that a strong science background should be made mandatory — even at the undergraduate level.

"Traditionally, the undergraduate students who spend most of their time in courses like English and humanities and not in science find themselves at high-risk in an academic curriculum like medical school. Suddenly, they are caught with a minimal level of the science they'll need in order to get through," he says.

Others aren't quite as convinced as Dr. Hutton, however, that science should be the focus of a premedical education.

Dr. Campbell at NEOUCOM readily admits that he, himself, was not a science major when he entered medical school, and he believes that premed students, today, actually study *more* science courses than they need.

"There should be more

humanity in medicine — especially now that it has become so technical," he says. "Maybe the best place to teach this is at the premedical school level — and, if that occurs at the expense of some of the science courses, I say so be it."

Dr. Sawyer at Wright State is also comfortable with medical school applicants who may have come from non-science backgrounds. For him he says, it is the knowledge and the skills of a student that impress him — no matter what discipline he or she may be from.

"I am impressed by students who take on a challenge and achieve it, whether that challenge is in music or chemistry."

Tomorrow's medical students, then, are perhaps best advised to follow their own interests in this area, secure in the knowledge that there will be a school for them, no matter which way they choose to go.

Yet, there remains one skill that all six deans agreed *must* be learned before a student sets foot inside a medical school of tomorrow — or today, for that matter — and that is computer literacy.

"There is still a little gap between those students who are being computerized now in schools — as far down as the elementary school level — and those who have never been computerized at all," says Dr. Sawyer.

It's a gap that must somehow be filled, say the deans, if a medical student expects to succeed in the school of tomorrow.

The new medical school

The *reason* tomorrow's medical school is as apt to boast as many computers as cadavers can be given in two simple words — "information explosion."

"Research has just exploded in recent years, making the amount of knowledge available today astronomical," says MCO's Dr. Standaert. "It is no longer possible to memorize everything there is to know about a subject."

He describes the "ideal" learning situation as a student who has been given a problem to solve by searching through the computer files for the data. "We need to make medical students more problem-oriented," he says.

Dr. Behrman agrees.

"The very essence of medical education is problem-solving. We have set aside a large part of time in our curriculum for integrated problem-solving, and I can see us setting aside a lot more time in the future."

And Wright State's Dr. Sawyer adds that "students today are paralyzed if they don't know how to get the information they need."

As a result, most of today's medical schools — particularly the University of Cincinnati and Case Western — have developed advanced computer laboratories where students can learn how to access information, and all six deans predict that tomorrow's medical students can expect to find even more microprocessors and other data systems in the classroom.

And not all of these systems will be used for information searches. A few may be used as teaching devices as well, as more medical schools adopt a participatory, interactive style of learning.

At Case Western, for example, Dr. Behrman says, "We are pretty much anti-lecture, in general, here. Most of the information is taught in small groups with much interaction, but I can definitely see more interactive methods of teaching evolving in the future — especially those which use computers."

MCO has, likewise, reduced by 25% the amount of time first-year medical students spend in formal lectures, and the University of Cincinnati is so committed to interactive education that they recently became one of three institutions in the country selected by the National Library of Medicine to test a revolutionary teaching tool — the voice-activated, interactive video disk. That disk involves the student in a video "drama" by presenting a "patient" — usually an actor — with "complaints." The disk then responds to the student's questions and orders, indicating, at each step of the way, what might result with



William Sawyer, MD
Dean, College of Medicine
Wright State University.

"Students today are paralyzed if they don't know how to get the information they need."



Frank Standaert, MD
Dean, Medical College of Ohio at Toledo.

"Medical education has always been an evolving field, but it is evolving more rapidly now than at any other time in history, and it will continue to evolve just as rapidly."

each selection. This kind of technology not only teaches students how to look at a problem and run through those mental processes necessary to solve it, says Dr. Hutton of his school's innovative new program, but computers can also evaluate whether the student has learned anything or not. To Dr. Hutton, this kind of interactive learning process is more effective than the lecture format where the material may be presented or received in varying degrees of quality.

"If the medical education process needs changing at all, it should be changed to help students *think* more about problems instead of simply memorizing facts. Students need to be taught how to look at a problem, and how to use the mental processes necessary to solve it. Information which is memorized may become outdated and, in the long run, prove to be incorrect. That's why the emphasis should be placed on how to *think*," says Dr. Hutton.

Does that mean, then, that the lecture format is rapidly becoming a thing of the past?

Dr. Campbell thinks not.

"We know the system has problems. Some people can't keep up — some lecturers are better than others, but the system has existed since (the year) 1300, and it wouldn't have been around that long if it didn't work."

OSU's Dr. Tzagournis also recognizes the weaknesses of a lecture format, and is aware of the complaints that there may be *too* many lectures, now, in medical school. He says that's one of the reasons why OSU developed an "independent study" program within the College of Medicine. Students here can opt to go at their own pace, using tutors and computers, or follow the more traditional lecture-discussion group path. The surprise, here, according to Dr. Tzagournis, is that two-thirds of the students *do* choose the more traditional process.

"People learn differently," comments Dr. Sawyer in way of explanation. "Some learn best by lectures, some by reading, some by hands-on experiences. That's why we make the learning process diverse, so one form or another doesn't dominate. Students have to learn what works best for them."

Future subjects

And what will medical students of the 21st century be learning *besides* computer skills and the best means of retrieving information?

"Medical education has always been an evolving field, but it is evolving more rapidly now than at any other time in history, and it will continue to evolve just as rapidly," says Dr. Standaert.

That means future medical students can expect to be introduced to subjects that were, once, only glossed over — or maybe never mentioned at all.

Nutrition seems to be one subject that was brought up over and over.

"We will see more emphasis placed on this subject in the future because the public has demanded it," says Dr. Campbell.

As he explains it, nutrition has always existed as a subject in medical schools, but usually as part of a larger whole — brought up, perhaps, in discussions about diabetes or in classes which cover coronary risks. Now, however, Dr. Campbell sees nutrition emerging soon as its own discipline — and, in fact, Dr. Behrman points with some pride to Case Western's medical school which is one of only a few in the country (and the only one in Ohio) to actually have its own nutrition department — already three years old.

"It helps too," adds Dr. Tzagournis, "that nutrition is a subject we now know more about."

What other subjects might future medical students expect to see added to the medical school curricula?

Medical economics is one subject Dr. Campbell would like to see added.

"We need more debates on this issue. We need to talk about cutting costs all the time, so we don't find ourselves cutting costs arbitrarily," he says.

Another prospect, says Dr. Standaert, is the neurosciences — a "classic example" of what has

become a "monstrous body of information," and one that is likely to spin off into new subject matter.

Genetics, immunology, specific medical ethics and preventive medicine were other ideas offered.

"I have difficulty knowing what will be discovered next year," says Dr. Sawyer, "but I think behavioral sciences will become a larger part of the curriculum — especially how to modify behavior in terms of smoking and substance abuse."

And Dr. Tzagournis believes medical schools of the future will have to devote equal — if not *more* time to outpatient, as opposed to inpatient, treatment.

"The HMOs, PPOs, and so on are making changes in our health-care system. They are demanding that costs be cut, and insisting that patients come in and be treated on an outpatient basis. We have to alter our curriculum to reflect this."

Today's students, for example, can no longer follow a surgery patient all the way through an inpatient setting. Now, says Dr. Tzagournis, arrangements must be made for the student to go to physicians' offices to observe any pre- and post-operative examinations.

And the student in ambulatory care settings must also adjust to making some quick decisions.

"When the patient was in a hospital," explains Dr. Tzagournis, "students could perform tests, ask the patient questions and, if they weren't sure of a diagnosis, they could go to the hospital library, check out their theories, and come back, do more tests, or ask more questions if they wanted."

Such movements are considered a luxury today, since ambulatory patients rarely stick around for that kind of careful fact-checking — let alone more medical tests.

"Ambulatory patients are traditionally healthier patients, and there is a shorter time-frame in dealing with them," says Dr. Tzagournis. "Today's student has to be well prepared when seeing these patients, because the diagnosis has to be quicker."

Dr. Standaert says that MCO is also doing a lot more teaching these days at outpatient clinics — and he points to the diversity of disease problems in these settings as the reason ambulatory care centers have become such a hot new training ground.

In hospitals, students see patients in the gastrointestinal ward, or the cardiology ward, and treat the patient accordingly, says Dr. Standaert. But in the outpatient clinic, the student immediately becomes a problem solver — testing his or her ability to seek out information and find a solution.

"It's good training," claims Dr. Standaert, "because, in practice, you never know what's coming through that door."

The "ideal" curriculum

In fact, that's why, if Dr. Standaert was to design an "ideal curriculum" for tomorrow's medical students, he would be sure to include some training in an outpatient clinic.

First, though, he says he would ask his students to begin with a basic knowledge of the sciences.

"Then, I would add a heavy layer of literature searches by computer, making sure the student knows how to find information and the solutions to problems."

Only *then*, he says, would he want to see how the student applies this information to human beings — preferably in the outpatient setting. MCO's Dr. Standaert agrees that some courses could actually benefit from a "time delay."

"To teach a freshman student about medical ethics is a waste of time," he says. "What does a freshman know about ethics in the context of medicine? He (she) hasn't seen the problems yet. Now, to a junior and senior medical student who has already seen and confronted these problems, it would be a very useful course."



Manuel Tzagournis, MD
Dean, Ohio State University College of Medicine.

"Today's student has to be well prepared when seeing (ambulatory patients) because the diagnosis has to be quicker."

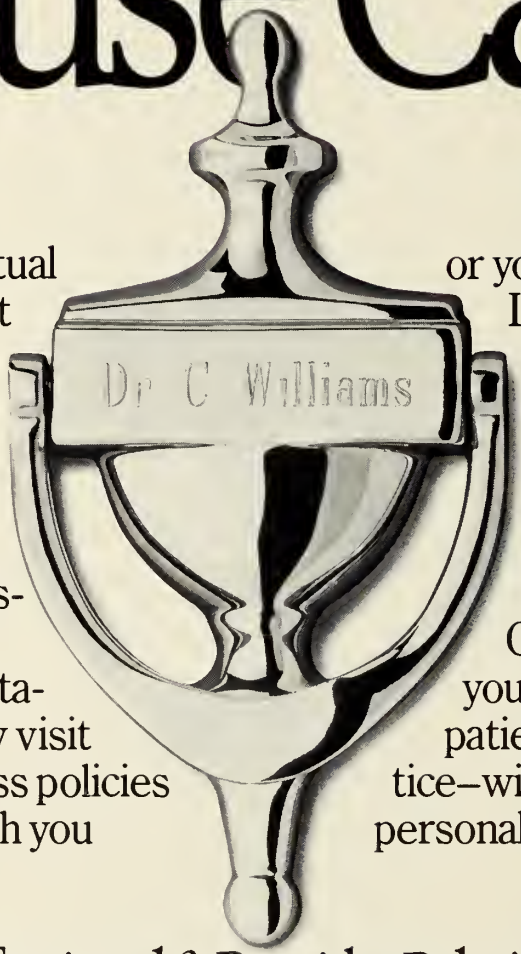
As far as the other four deans are concerned, however, they are, for the most part, content with their medical school's present-day curriculum.

"We do things a little differently here at Case Western, and I don't think I would change much from the way we are currently teaching medicine," says Dr. Behrman.

He points out that the medical school there is not structured into departments.

"Instead, we teach in clusters

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Colin Campbell, MD
Dean, Northeastern Ohio Universities College of Medicine.

"If I were to design an ideal curriculum for the student of the 21st-century, I don't think it would look any different from the way it looks today."

around the body's different organ systems," he says.

It's a different approach to the curriculum, and one he says has been picked up "in bits and pieces" by other medical schools — including Harvard and McMasters in Canada.

Dr. Behrman doubts, however, if this type of structure would lend itself to the future.

"It would be very difficult to see medical schools adapting this format because it is very difficult, politically, for faculty to give up departmental territories. I inherited this system, and it's been very successful for us — it holds student interest. But I would not have liked to have been around when this system was first getting off the ground."

As far as Dr. Hutton at the University of Cincinnati is concerned, it's not the content he would change as much as the methods of teaching.

"I would work to stress the analysis of problems and how to solve those problems."

Dr. Tzagournis, also, is not that eager to change a program he says he is comfortable with.

"I *would* insist on a good working knowledge of the basic sciences, and maybe include courses in humanities, ethics and some of the new subjects discussed earlier," he says.

Then, the last two years, there would be lots of practical experience.

"Students would come out with a good working knowledge of how to interact with patients. All in all, however, the program would not be that much different."

Which is the same point Dr. Campbell at NEOUCOM would like to make.

"If I were to design an ideal curriculum for the student of the 21st-century," he says with a laugh, "I don't think it would look any different from the way it appears today."

For despite the declining numbers, the predictions and the educated guesses about the future, medicine, it appears, is still medicine — a time-honored and finely-honed profession, and one that continues to age remarkably well. **OSMA**

Karen S. Edwards is the Executive Editor of **OHIO Medicine.**

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The Future of Medical Education:

By Cindy J. Smith

The preceding article is based on interviews with the deans of each of Ohio's six schools of medicine. In the interviews, the deans are asked for their perspectives on the future of medical education. In this article, students from each of the six medical schools have been asked the same questions that were asked of the deans in order to gain a student perspective on the future of medical education. Representative responses from each question have been included.

When asked about premedical education in terms of what it should be teaching or emphasizing, students responded with a variety of opinions. The majority of the students interviewed believed that premedical education should be broader and less focused on science.

"Premedical backgrounds are so heavily scientific that medical students don't know how to communicate in the English language. I think that lack of a broad education is part of our problem with physician image. The physician used to be a very educated man or woman; that is no longer true."

"It is important for students to be able to major in something other than science without feeling that they're hurting their chances of getting in."

Although most of the students interviewed thought that premedical education should be broad and less focused on science, there was sharp dissent.

"Undergraduate education needs to focus in on the sciences."

Students were sharply divided on the question of length of the medical education process and the question of expense of medical education. Almost all students agreed that the expense of medical education is and will continue to be a factor in declining applications and enrollment.

"The length of medical education is beginning to border on too short because of the broad base of material that students are expected to master."

"Too long (medical education). Much of what we learn is obsolete in two to three years and much is so specialized that it cannot be used clinically."

"It is probably too short but if it was any longer people really wouldn't want to do it."

Most students interviewed would be willing to actively recruit future medical students to avoid declining applications and enrollment. The interviewees felt that an appropriate role for medical students in the recruitment process would be participating in educational and community service events with junior high and high school students. One student felt strongly that recruitment of medical students would be highly inappropriate.

"Medical students can be used to speak to junior high and high school students on any topic and provide a positive role model and promote positive attitudes about medical school."

"If we are in such bad shape that we need to recruit people, we need to change something within medicine to make it more attractive to people again. Rather than recruit people, we would have

A Student's Perspective

to close the doors and clean up the house. I just can't see recruiting medical students."

Students unanimously felt that very little had been done in Ohio schools in moving away from traditional, lecture-type learning and toward active participatory learning.

"First and second year is just about all lecture."

"All material is primarily presented in lecture format."

"It would be refreshing to have more participatory learning instead of lectures."

When asked if some subjects were being neglected — like ethics, humanities and social sciences — most of the students in this interview felt that their schools had made substantial efforts to cover those topics.

"Yes, I think the humanities are somewhat neglected, but my school and other schools are increasing the time that is spent on those subjects."

"Schools have begun to do a good job teaching humanities and ethics."

Students were asked to respond to the question, "Will there be more emphasis placed on interprofessional roles in the future?"

"I would hope so because it's a health-care *team.* If everyone doesn't communicate, patient care suffers."

"My school appears to be emphasizing interprofessional relations."

"Yes. All of the other allied medical professions continue to increase their technologies."

Students were asked about changes in medical education in the future and what they would include in an ideal curriculum for the 21st century. There were some significant recurrent themes in their answers that could be summarized as follows:

1) Clinical education needs to be instigated in the first year of medical education and be more tightly integrated with basic science instruction throughout the medical education process.
2) Lecture and memorization of facts need to be de-emphasized. More opportunities for small group and other kinds of participatory learning need to be planned.
3) Ethics, social sciences and humanities need continued emphasis.
4) Basic science education needs to be more practically-oriented and less research-oriented.

It is clear from the interviews with medical school students that Ohio students are thinking about the future of medical education and the future of medicine. I would like to thank the following students who were interviewed and quoted in this article.

George Askew — Case Western Reserve University
Stacey Hollaway — NEOUCOM
Stephen Gilreath — Univ. of Cincinnati, Alternate Delegate to the AMA
Derrick Jeter — WSU, President OSMA-MSS
Ted Meineke — OSU
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Cindy J. Smith is a second-year medical student at Wright State University's School of Medicine.

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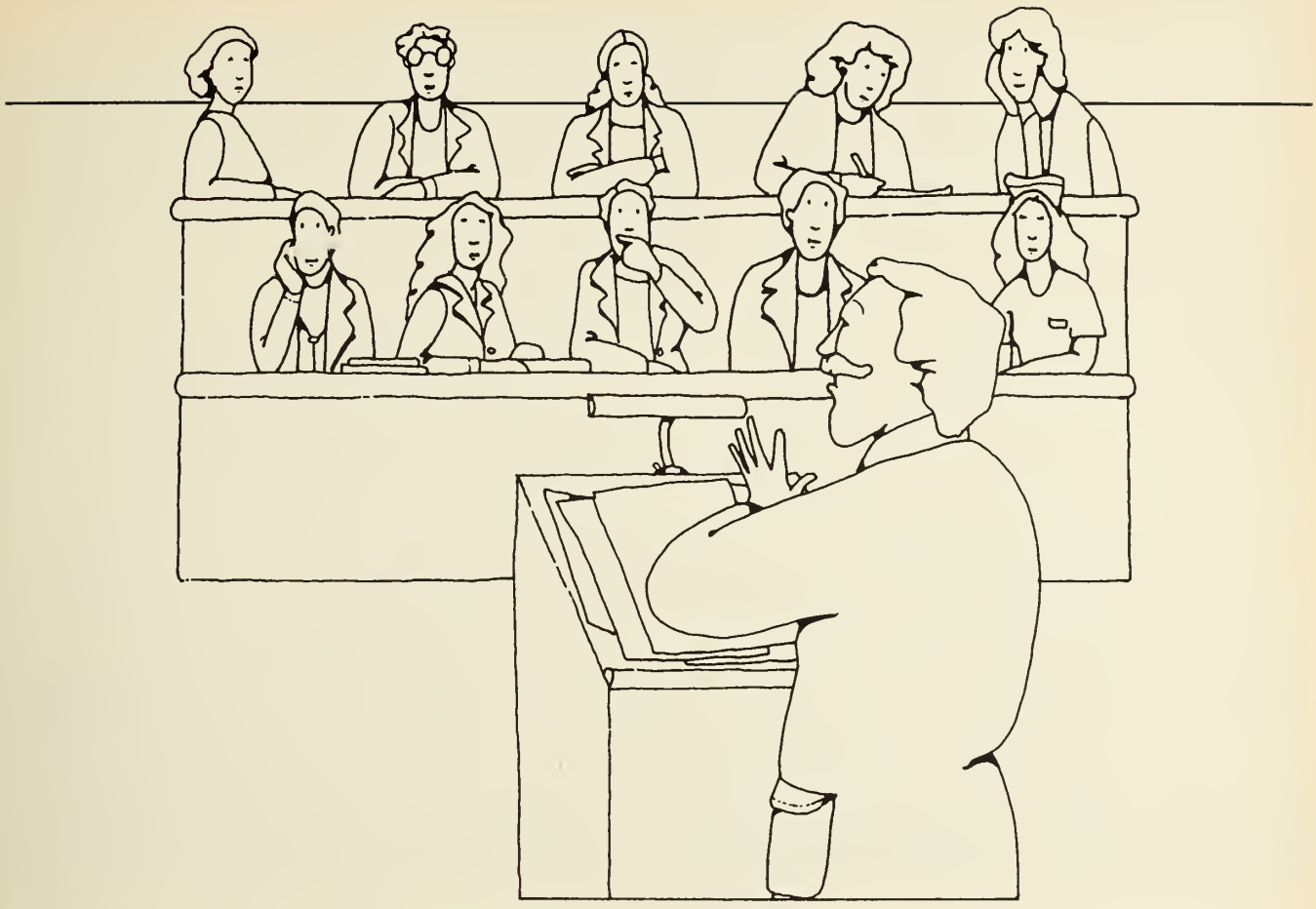
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Reducing the Stress of a Medical Education: Two Approaches

By Kathleen S. Franco, MD, Marijo B. Tamburrino, MD, Brendan T. Carroll, MD, Anita Somani, and Steven M. Wagner, MD

Much concern has been expressed, recently, about the emotionally detrimental effect medical school has on students. Entering trainees, for example, are described as bright, successful, highly-motivated and energetic. They express few doubts regarding career choice, and are less likely to experience feelings of inadequacy than upperclassmen. However, the new students soon experience overwhelming work demands, increasing loneliness, loss of self-esteem and perceptions of being devalued by faculty. In addition, increased cynicism and a loss of humanitarianism among students are believed to be results of the medical school environment. As a result, more concern has been expressed that students are turning to chemical dependency, either alcohol or drug-related, in an effort to cope. (See related sidebar story for the authors' own findings in this area).

At the Medical College of Ohio at Toledo, two distinctly different pilot programs were offered to first-year medical students in an attempt to reduce the stress and

ease the transition into medical training. The two pilot programs, and the effects each had, are outlined below.

The Student-Mentor Program

R. Gardner, who has done much work in the area of stress on first-year medical students, proposed in one of his articles a unique way to increase student-faculty liaison. His approach was to offer students up to $100 for consistently writing essays to a faculty member about their feelings, or what they were experiencing in medical school. The faculty member would read, and then return the essay to the student with a supportive written response.

We believed that a closer relationship with a faculty member, in and of itself, might be an adequate reward for many, since first-year students often feel distanced from clinicians when they're immersed in basic science studies. It was decided that a pilot "student-mentor" program would be established, and that volunteer mentors would be selected from practicing physicians.

By the end of the school year, the students reported that they had received written correspondence from their mentors one to 12 times. Both the number of written messages and the face-to-face contact between student and mentor remained consistent. By this time, students ranked the following as benefits:

- provision of encouraging advice
- help with setting priorities in school and in personal life
- recommendations regarding academic growth

The majority were quite positive about the relationship they had with their mentor and desired to maintain contact. All felt the program should be continued, and all but one wanted the program to be open to students in other classes.

The majority of the faculty described their enjoyment of the personal contact with their students and their enjoyment of giving support. Problem solving and an enjoyable break from routine were other advantages described.

However, some students reported feeling frustrated by the time lapse between responses; others wished they had more time to spend with their mentors. One student requested more structure for the interactions and others said they felt more like a patient in the relationship. Seven mentors, on the other hand, questioned whether or not their students liked them or, for some reason, did not wish to interact with them personally. Several felt the students should initiate the first contact and carry the responsibility to maintain the relationship. Only a few felt they were too busy to do the job well. Others wished for more frequent and longer contacts with the students.

Informal Support Groups

Yet another program initiated at MCO in an attempt to reduce the stress of medical education on first-year students, was the formation of informal support groups.

First-year medical students, consisting of 150 men and women, were divided into seven groups: four of which were coeducational; two were female; one was male. Each group was assigned to one member of the dean's staff (an associate dean) who served as a group leader and liaison between students and administration. Students were encouraged to discuss such concerns as curricula, establishing professional identity and socioeconomic pressures.

Seventy-five percent of the class attended one or more group meetings. Survey results showed that students attended the meetings to:

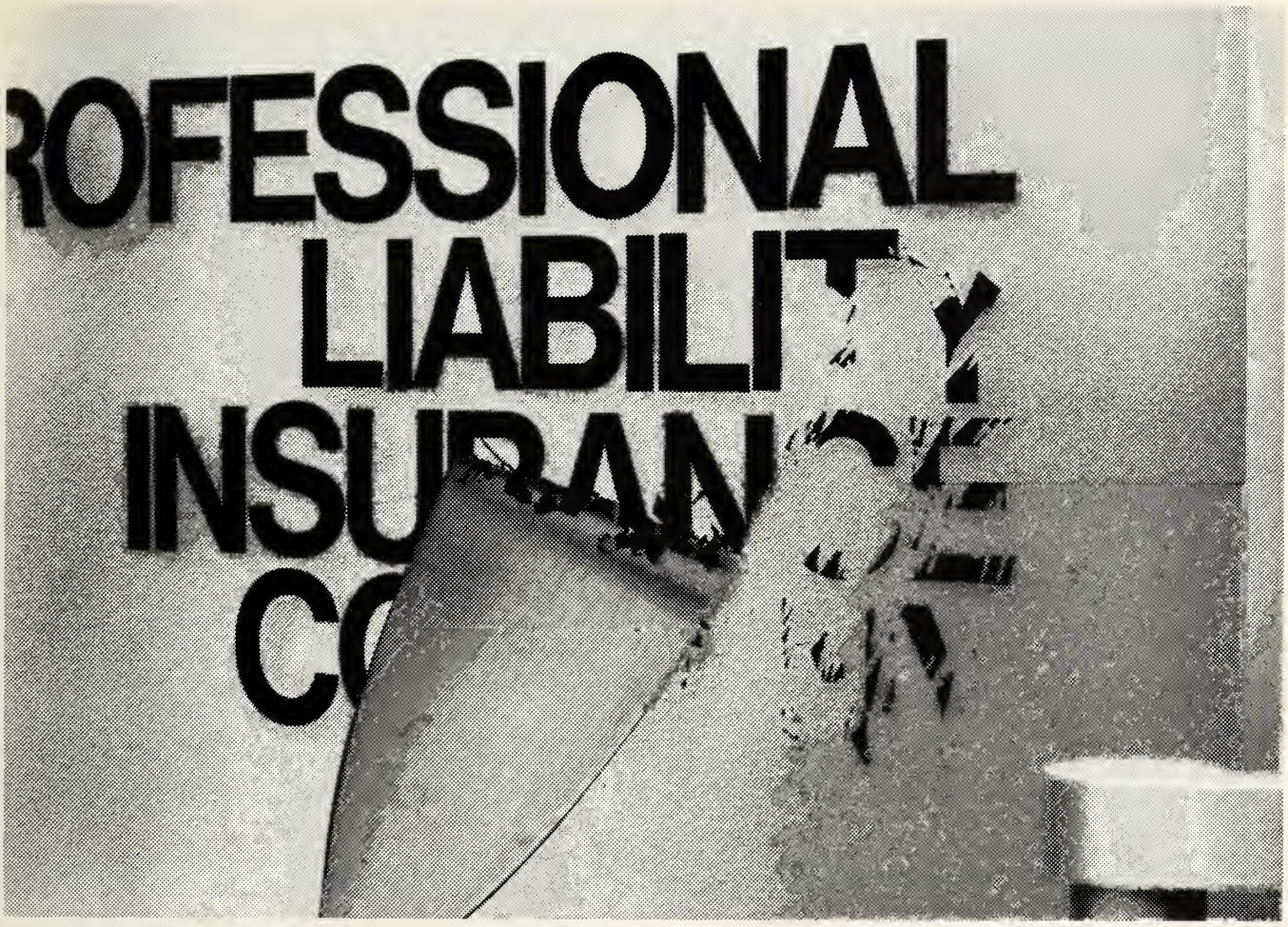
- gain insight into medical training
- express feelings
- open discussion of problems in hope that a solution might be found
- gain group and/or leader support

Those who chose not to attend cited "lack of time" (especially true for those who were not doing well academically, and felt they could not afford to take time from their studies); discomfort with other group members; and the group's ineffectiveness in helping students feel better.

Eighty percent of the students who responded to the survey thought the groups should continue to be offered to first-year students. Forty-two percent of those students believed the groups should be continued through the fourth year of medical school.

It is hoped that these readily-implemented and continuing interventions can lessen the stress of medical students, and sensitize them to the ongoing need for care of the care taker. **OSMA**

Kathleen S. Franco is an associate professor of psychiatry, and director of the Consultation-Liaison program, Department of Psychiatry, Medical College of Ohio. Marijo Tamburrino, MD, and Steven M. Wagner, MD, are physicians; Brendan T. Carroll, MD, a graduate medical student, and Anita Somani, a medical student, are involved with the programs at MCO, mentioned in this article.



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Continuing Medical Education — Is it Worth It?

By Susan Porter

Continuing Medical Education. For some it brings to mind free meals, tax-exempt Caribbean cruises or brief attendances at seminars or workshops, spending just enough time to sign in and sign out. For others, it is a nuisance, a state requirement — just another example of how government has managed to take control of the practice of medicine. And for most Ohio physicians, CME represents an opportunity to stay abreast of the rapid advances taking place in their specialty or field, as well as a chance to keep up-to-date on changes in the socioeconomic climate of medicine.

CME is all of these things and more, according to those presenting a special OSMA workshop on the topic held recently in Columbus.

Some $15 million is spent on CME in Ohio each year, points out Alvin E. Rodin, MD, a member of the OSMA Committee on Accreditation and the keynote speaker at the seminar. Thus, in addition to the above, CME is a big business — a way for pharmaceutical companies, hospitals and other sponsors to market their services and products to a captive physician audience.

Ohio is one of only 17 states which mandate CME for physicians, and despite some protests, the requirement that physicians complete at least 100 hours of continuing medical

"Medical knowledge and skills are far down on (the patient's) list of concerns. Most assume that a medical degree and a license assure competence."

education every two years remains intact. This mandate "was based on the perception that certain members of the medical community were not keeping up in their profession," Dr. Rodin explains. And while it may be inaccurate in the majority of cases, "it is a perception that is hard to change," says Dr. Rodin. "No doubt, CME does help," he adds. "And it makes a lot of people feel better" about the competency of physicians and the quality of care in this state.

But CME must go beyond all of these parameters if it is to be a viable contributor to the quality of health care today, says Dr. Rodin, adding that attitudes are as important as knowledge in the delivery of care. "Knowing is not necessarily the same as doing," says Dr. Rodin. "And to know but not to apply is even more reprehensible than not to do at all."

What's more, "To do in an aloof and sterile manner is not optimal medical practice," Dr. Rodin continues. "We must have a commitment to apply what we know, which involves attitudes as well as knowledge. And attitudes are more difficult to change than outdated knowledge."

According to the Accreditation Council for Continuing Medical Education (ACCME), the organization which sets the criteria and standards for CME accreditation in this state, "Continuing medical education consists of educational activities which serve to maintain, develop or increase the knowledge, skill and *professional performance and relationships* (emphasis added) that a physician uses to provide services for patients, the public or the profession."

Patient surveys show, according to Dr. Rodin, that the public is more concerned about how physicians treat their patients than what they know. "Medical knowledge and skills are far down on their lists of concerns," says Dr. Rodin. "Most assume that a medical degree and a license assure competence."

Instead, 96% of those surveyed in a Columbus study gave as top priority the need for doctors to "answer questions honestly and openly," while 95% wanted them to "explain problems in clear language."

On the other hand, the majority of those dissatisfied with their physicians cited "doctor didn't spend enough time with me," as the reason, while "doctor didn't have a friendly personality" and "doctor didn't answer questions honestly or completely" were other major reasons these individuals stopped going to their doctors.

"The major concern of the public is how physicians act toward their patients," says Dr. Rodin. "It is a behavioral skill that often students don't learn in undergraduate, graduate or medical education."

Thus, it is up to CME programs to fill that gap, Dr. Rodin and others believe. To be worthwhile, "CME must be devoted not only to skills, but to caring for each patient as a human being," says Dr. Rodin.

So how can CME programs best accomplish the monumental tasks set before them, helping physicians to become not only more competent practitioners but also more compassionate healers? Harvey J. Dworken, MD, who also serves on the OSMA Committee on Accreditation and spoke at the seminar, explains that individuals learn in two different ways — and that both ways can be implemented to accomplish CME's multiple goals.

The first manner of learning -- known as Category 1 CME — is instructor-oriented or guided education. It is formal, planned and must meet certain essential requirements, Dr. Dworken points out. In fact, most education which takes place in this country — through grammar school, high school, college and professional school — could be described as Category 1. The AMA requires that 40% of the CME credits physicians accrue to meet their licensing requirements be of this category.

Category 2 CME, on the other

The traditional lecture method of education is not enough. One reason is because it lends itself to inactive participation.

hand, is unstructured or self-guided education which trusts the learner to be his or her own teacher. Activities include reading journals and text books, attending grand rounds and ward consultations, or simply observing new techniques and technologies. While up to 60% of a physician's CME can be of this category, it is often viewed as inferior to the more structured and supervised Category 1 CME, says Dr. Dworken, even though it can go a long way in accomplishing CME's goals and purposes.

Just as a visit to a museum, a drive to a strange city or the repair of a leaky faucet can all present valuable opportunities for self-education, reflection and enlightenment, CME Category 2 experiences allow the physician to explore his or her own interests and experiences as a means to a better understanding and practice of medicine.

"Categories 1 and 2 are co-equal — they supplement each other," Dr. Dworken says. "Neither is superior to the other."

Even the more structured Category 1 classes can be presented in a unique and informative manner so that they are valuable to the practicing physician — and not just an update of what he or she learned in medical school. "Non-traditional methods must be used — not the recall of information, but the understanding and application of knowledge," says Dr. Rodin.

The traditional lecture method of education, followed by a simple questionnaire to test knowledge and opinion is not enough, he says. One reason is because it lends itself to inactive participation — and allows physicians to make token appearances at programs, eat the lunches provided, or take advantage of the cruise — and learn little or nothing.

Another barrier to this type of learning is the lecturn itself, says Dr. Rodin, which puts a psychological block between instructor and learner, setting the teacher up as an authority figure and the physician as a blind follower.

On the other hand, CME courses which demand that physicians roll up their sleeves and take some responsibility for their own learning have a much greater impact, says Dr. Rodin. Programs which allow participants to become active problem solvers, encourage self-examination and challenge their skills and techniques enhance not only knowledge but also patient care.

"Case histories should be used and examined," Dr. Rodin suggests, and "emphasis should be placed not on diagnoses, but on diagnostic and therapeutic problem solving."

Likewise, follow-up evaluations to such experiences should not be limited to the brief questionnaire or "happiness index" passed out at the end of the course which asks participants to rate the instructor's speaking ability, the relevance of the material presented or the comfort level in the room. "This gives no indication that understanding has occurred or that retention will result," says Dr. Rodin.

Instead, he suggests that three months after the course, a follow-up survey be mailed to all attendees. Questions should include:

1. As a result of the program, what are you doing differently today?
2. What changes have you made in diagnosis, treatment and follow-up of your patients?
3. Give us one or more examples of how you have changed your practice patterns or used the information presented in the course.

This allows the value of any CME course to be determined in a specific and meaningful fashion, says Dr. Rodin. It also helps to decide which types of seminars and workshops help physicians the most in their daily practices — and limits the presentation of CME programs for purposes largely superfluous to physician education.

For example, drug companies are notorious for sponsoring or supporting CME programs which aim simply to introduce physicians to a new product. While information about new drugs and technologies is an important function of CME, that alone does not justify having a CME program, says Albert N. May, MD, who discussed joint sponsorships of CME programs at the seminar.

Likewise, hospitals are now using CME courses as a marketing tool in order to draw physicians and smaller outlying hospitals into their service areas. Those hospitals having financial problems and budget cuts often view CME as "the first thing to go," says Dr.

May. Thus, larger institutions come forward with CME programs that they can offer at little or no cost to these physicians.

"There is a danger that soon education as a concept will be lost," says Dr. May, "and that CME will simply become a subsidiary of marketing."

Yet, to be of real value to physicians, CME programs must be tailored to meet the individual needs of physicians in their own hospitals and communities — something the large, institution-sponsored CME courses may not accomplish. The question to ask when adopting such programs, says Dr. May, is "Do these programs speak to the needs of the medical staff? Do they really fill the educational bill?"

Not all joint sponsorships are bad, however, both Dr. May and others are quick to point out. Due to the high cost of speakers for CME programs, the support of pharmaceutical companies is often required if the seminars are to be affordable, says John O. Lindower, MD, another speaker at the seminar.

These co-sponsors can also provide outside help and expertise in planning and implementing a program, bringing in nationally-known speakers to address topics important in the health care field, Dr. Lindower points out. And drug companies, as well as health care providers, have a legitimate interest in CME and in assuring that new products and technologies are used correctly by physicians.

Still, it is essential that the sponsoring organization maintain control of the program and not allow a financial supporter to dictate the purpose or content of the course, both Dr. Lindower and Dr. May agree.

What's more, physicians should be aware of programs that offer free steak dinners, plush hotel rooms and exotic settings for their CME credits. In many cases, the perks represent the sum total of what the CME program has to offer.

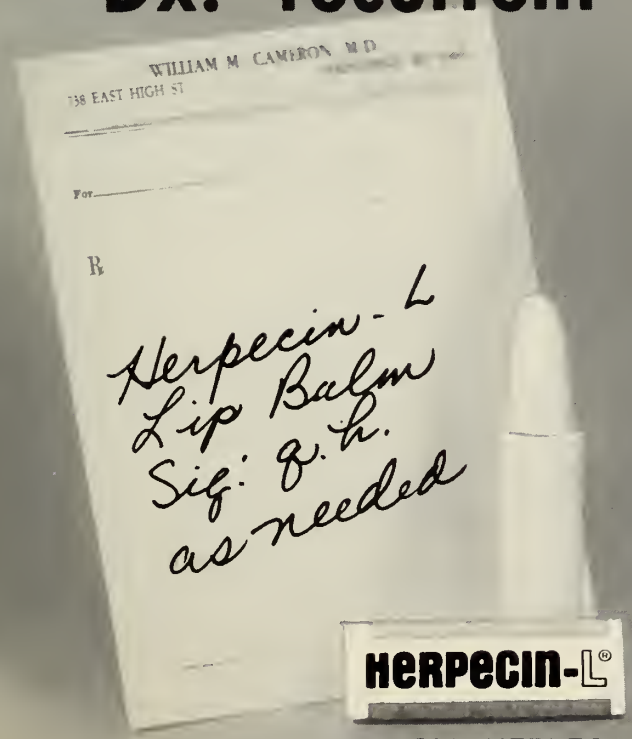
Susan Porter is a free-lance writer in Columbus and former associate editor of **OHIO Medicine.**

Quotes of Note

"Overall, the best way to get new patients is through old patients."

— Garry Feno, MD, Healthcheck

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AIDS: Recommendations & Guidelines

(Nov. 1982-Nov. 1986)

Health-Care Workers And Laboratory Personnel

EDITOR'S NOTE: *This article and subsequent articles which will appear in future issues of* **OHIO Medicine** *are being run at the suggestion of the OSMA AIDS Task Force, to educate physicians on adequate AIDS safeguards, established by the Centers for Disease Control. These recommendations for health-care workers have recently been updated, and a revised copy can be obtained by writing the U.S. Dept. of HHS, Centers for Disease Control, Atlanta, Georgia 30333.*

The etiology of the underlying immune deficiencies seen in AIDS cases is unknown. One hypothesis consistent with current observations is that a transmissible agent may be involved. If so, transmission of the agent would appear most commonly to require intimate, direct contact involving mucosal surfaces, such as sexual contact among homosexual males, or through parenteral spread, such as occurs among intravenous drug abusers and possibly hemophilia patients using Factor VIII products. Airborne spread and interpersonal spread through casual contact do not seem likely. These patterns resemble the distribution of disease and modes of spread of hepatitis B virus, and hepatitis B virus infections occur very frequently among AIDS cases.

There is presently no evidence of AIDS transmission to hospital personnel from contact with affected patients or clinical specimens. Because of concern about a possible transmissible agent, however, interim suggestions are appropriate to guide patient-care and laboratory personnel, including those whose work involves experimental animals. At present, it appears prudent for hospital personnel to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis B virus infection, in which blood and body fluids likely to have been contaminated with blood are considered infective. Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin and mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS. The following precautions do not specifically address outpatient care, dental care, surgery, necropsy, or hemodialysis of AIDS patients. In general, procedures appropriate for patients known to be infected with hepatitis B virus are advised, and blood and organs of AIDS patients should not be donated.

The precautions that follow are advised for persons and specimens from persons with: opportunistic infections that are not associated with underlying immunosuppressive disease or therapy; Kaposi's sarcoma (patients under 60 years of age); chronic generalized lymphadenopathy, unexplained weight loss and/or prolonged unexplained fever in persons who belong to groups with apparently increased risks of AIDS (homosexual males, intravenous drug abusers, Haitian entrants, hemophiliacs); and possible AIDS (hospitalized for evaluation). Hospitals and laboratories should adapt the following suggested precautions to their individual circumstances; these

recommendations are not meant to restrict hospitals from implementing additional precautions.

A. The following precautions are advised in providing care to AIDS patients:

1. Extraordinary care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material and to avoid contact of open skin lesions with material from AIDS patients.
2. Gloves should be worn when handling blood specimens, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials, and objects exposed to them.
3. Gowns should be worn when clothing may be soiled with body fluids, blood, secretions, or excretions.
4. Hands should be washed after removing gowns and gloves and before leaving the rooms of known or suspected AIDS patients. Hands should also be washed thoroughly and immediately if they become contaminated with blood.
5. Blood and other specimens should be labeled prominently with a special warning, such as "Blood Precautions" or "AIDS Precautions." If the outside of the specimen container is visibly contaminated with blood, it should be cleaned with a disinfectant (such as a 1:10 dilution of 5.25% sodium hypochlorite [household bleach] with water). All blood specimens should be placed in a second container, such as an impervious bag, for transport. The container or bag should be examined carefully for leaks or cracks.
6. Blood spills should be cleaned up promptly with a disinfectant solution, such as sodium hypochlorite (see above).
7. Articles soiled with blood should be placed in an impervious bag prominently labeled "AIDS Precautions" or "Blood Precautions" before being sent for reprocessing or disposal. Alternatively, such contaminated items may be placed in plastic bags of a particular color designated solely for disposal of infectious wastes by the hospital. Disposable items should be incinerated or disposed of in accord with the hospital's policies for disposal of infectious wastes. Reusable items should be reprocessed in accord with hospital policies for hepatitis B virus-contaminated items. Lensed instruments should be sterilized after use on AIDS patients.
8. Needles should not be bent after use, but should be promptly placed in a puncture-resistant container used solely for such disposal. Needles should not be reinserted into their original sheaths before being discarded into the container, since this is a common cause of needle injury.
9. Disposable syringes and needles are preferred. Only needle-locking syringes or one-piece needle-syringe units should be used to aspirate fluids from patients, so that collected fluid can be safely discharged through the needle, if desired. If reusable syringes are employed, they should be decontaminated before reprocessing.
10. A private room is indicated for patients who are too ill to use good hygiene, such as those with profuse diarrhea, fecal incontinence, or altered behavior secondary to central nervous system infections.

Precautions appropriate for particular infections that concurrently occur in AIDS patients should be added to the above, if needed.

B. The following precautions are advised for persons performing laboratory tests or studies on clinical specimens or other potentially infectious materials (such as inoculated tissue cultures, embryonated eggs, animal tissues, etc.) from known or suspected AIDS cases:

1. Mechanical pipetting devices should be used for the manipulation of all liquids in the laboratory. Mouth pipetting should not be allowed.
2. Needles and syringes should be handled as stipulated in Section A (above).
3. Laboratory coats, gowns or uniforms should be worn while working with potentially infectious materials and should be discarded appropriately before leaving the laboratory.
4. Gloves should be worn to avoid skin contact with blood, specimens containing blood, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials, and objects exposed to them.
5. All procedures and manipulations of potentially infectious material should be performed carefully to minimize the creation of droplets and aerosols.
6. Biological safety cabinets (Class I or II) and other primary containment devices (e.g., centrifuge safety cups) are advised whenever procedures are conducted that have a high potential for creating aerosols or infectious droplets. These include centrifugin, blending, sonicating, vigorous mixing, and harvesting infected tissues from animals or embryonated eggs. Fluorescent activated cell sorters generate droplets that could potentially result in infectious aerosols. Translucent plastic shielding between the

continued on next page

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droplet-collecting area and the equipment operator should be used to reduce the presently uncertain magnitude of this risk. Primary containment devices are also used in handling materials that might contain concentrated infectious agents or organisms in greater quantities than expected in clinical specimens.

7. Laboratory work surfaces should be decontaminated with a disinfectant, such as sodium hypochlorite solution (see A5 above), following any spill of potentially infectious material and at the completion of work activities.
8. All potentially contaminated materials used in laboratory tests should be decontaminated, preferably by autoclaving, before disposal or reprocessing.
9. All personnel should wash their hands following completion of laboratory activities, removal of protective clothing, and before leaving the laboratory.

C. The following additional precautions are advised for studies involving experimental animals inoculated with tissues or other potentially infectious materials from individuals with known or suspected AIDS.

1. Laboratory coats, gowns or uniforms should be worn by personnel entering rooms housing inoculated animals. Certain nonhuman primates, such as chimpanzees, are prone to throw excreta and to spit at attendants; personnel attending inoculated animals should wear molded surgical masks and goggles or other equipment sufficient to prevent potentially infective droplets from reaching the mucosal surfaces of their mouths, nares, and eyes. In addition, when handled, other animals may disturb excreta in their bedding. Therefore, the above precautions should be taken when handling them.
2. Personnel should wear gloves for all activities involving direct contact with experimental animals and their bedding and cages. Such manipulations should be performed carefully to minimize the creation of aerosols and droplets.
3. Necropsy of experimental animals should be conducted by personnel wearing gowns and gloves. If procedures generating aerosols are performed, masks and goggles should be worn.
4. Extraordinary care must be taken to avoid accidental sticks or cuts with sharp instruments contaminated with body fluids or tissues of experimental animals inoculated with material from AIDS patients.
5. Animal cages should be decontaminated, preferably by autoclaving, before they are cleaned and washed.
6. Only needle-locking syringes or one-piece needle-syringe units should be used to inject potentially infectious fluids into experimental animals.

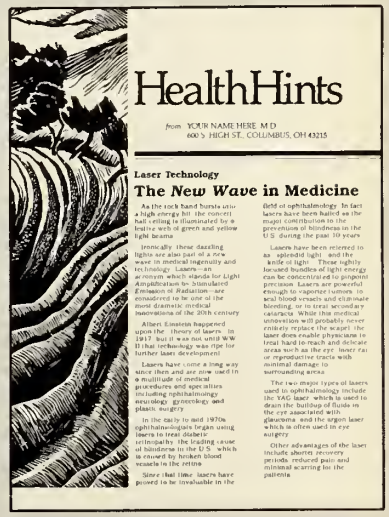
The above precautions are intended to apply to both clinical and research laboratories. Biological safety cabinets and other safety equipment may not be generally available in clinical laboratories. Assistance should be sought from a microbiology laboratory, as needed, to assure containment facilities are adequate to permit laboratory tests to be conducted safely.

Reported by Hospital Infections Program, Div. of Viral Diseases, Div. of Host Factors, Div. of Hepatitis and Viral Enteritis, AIDS Activity, Center for Infectious Diseases, Office of Biosafety, CDC; Div. of Safety, National Institutes of Health.

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The Columbus Dispatch
OHIO'S GREATEST HOME NEWSPAPER
THURSDAY, AUG. 13, 1987

Time limit for malpractice suits dropped

Court's decision a blow for Ohio's doctors, hospitals

By Roger K. Lowe
Dispatch Statehouse Reporter

Striking a major blow to the medical profession, the Ohio Supreme Court yesterday wiped out the 4-year time limit for filing medical malpractice suits.

The court ruled the statute of limitations unconstitutional. It said that in many cases the time limit would bar a victim's claim even before an injury is discovered. In some instances, an injury caused by malpractice does not become apparent for years, the court said.

The decision may make malpractice insurance unavailable or unaffordable, some medical professionals and justices said.

IN A 4-3 decision written by Justice Herbert R. Brown, the court said that under the law, "The courts of Ohio are closed to those who are not reasonably able, within four years, to know of the bodily injury they have suffered."

The ruling "is going to have a dramatic impact on rates immediately," said William Todd, counsel to the Ohio State Medical Association.

Companies providing medical malpractice insurance will have to build reserves to cover potential losses from claims that may not come for decades, he said. Money for those reserves will come from higher insurance rates paid by doctors and hospitals.

TODD SAID the association will seek help from the Ohio General Assembly. That could include an insurance pool or using state money to pay claims based on procedures used long ago.

The decision involves a case in which one doctor sued another.

In 1972, Dr. Carl E. Hardy of Gainesville, Fla., developed partial loss of hearing in his right ear. Dr. Victor R. VerMeulen of Columbus performed surgery on March 15, 1973, and, because of complications, again on Dec. 13. Surgery was performed a third time on March 28, 1974.

HARDY SAID he discovered April 15, 1984 that his hearing problem had been caused by surgery. In his suit, Hardy said VerMeulen's surgery and care were below standard. Hardy claimed he was permanently and totally deaf in the ear and claimed future lost earnings of more than $1 million.

Hardy's suit was dismissed in Franklin County Common Pleas Court because it was not filed within 4 years of the surgery. The Franklin County Court of Appeals upheld the decision, but the Supreme Court reversed the lower courts and sent the case back for trial.

Justices Andrew Douglas, Ralph S. Locher and A. William Sweeney concurred with Brown. Justices Robert E. Holmes and Craig Wright and Cuyahoga County Court of Appeals Judge Richard M. Markus, sitting by assignment, dissented.

Holmes noted said the General Assembly adopted a statute of limitation in response to a medical malpractice insurance crisis; "This court, in determining that such legislation is unconstitutional...sets itself apart as a super legislative body usurping the very constitutional prerogatives of the General Assembly," he wrote.

Wright wrote that the ruling "creates a constitutional dilemma of severe proportions" by telling the General Assembly that legislation cannot be adopted in response to what it perceives as a crisis.

"The present predicament that the medical profession and health care facilities have in obtaining malpractice insurance at a reasonable cost will rapidly spread to other professions," Wright wrote.

"Insurance companies are not in the business to sustain losses and thus they will not accept a risk where their exposure is incalculable.

AN IMPORTANT MESSAGE TO OHIO PHYSICIANS

RECENT OHIO SUPREME COURT RULING REMOVES STATUTE OF LIMITATIONS ON FILING MALPRACTICE CLAIMS

The Ohio Supreme Court's unexpected ruling on August 12, 1987 that eliminated the statute of limitations on filing medical professional liability claims has a severe impact on physicians. Essentially, it means that physicians now are never freed from the possibility of claims arising from past performance of medical services.

Here are several recommendations to deal with this additional threat to your financial security.

- Maintain all past, current and future medical records in a place that is safe and secure.
- Maintain a file on medical malpractice insurance coverage with a list of your insurers, policy dates and limits of coverage. Retain copies of policy contracts. Check to see if all past insurers still are conducting business and if they are in a position to handle any claim that may arise.
- If you had claims-made coverage at any time in the past, check to see if tail coverage was purchased following termination of that policy. If not, you may have exposure which is not covered by insurance.
- Maintain up-to-date address information on nursing staff and other support staff associated with you in past years, in the event their testimony may be needed at some future time.
- Encourage and support appropriate efforts to re-establish a statute of limitations in Ohio and other attempts to restore stability to the medical professional liability situation.

Obviously, the Ohio Supreme Court ruling also has strong impact on those who insure Ohio physicians. Loss reserves and rate levels must reflect the additional claims exposure. Experienced, qualified legal counsel must be available to assist in appropriate and timely defense actions.

As a result of the Ohio Supreme Court's action, PICO has made a special addition to loss reserves of $8.1 million, bringing the company's total direct loss reserves to more than $102 million. These reserves are considered to be actuarially adequate for all future claims. Since PICO's rates are based upon up-to-date actuarial data, no future special additions to loss reserves are anticipated.

In summation, Ohio physicians now have additional exposure to medical malpractice claims arising from past, present and future medical services. So do their insurers.

Now, more than ever, quality coverage for physicians and fiscal conservatism by insurers is essential. It may be difficult for you to worry in 1987 about a claim that may be presented in the year 2000, thirteen years from now. That's probably how most Ohio physicians felt in 1972 about the claim that was presented in 1984 and which led to the Ohio Supreme Court's landmark ruling in 1987.

Medical professional liability protection is a long-term commitment for PICO. We will be around in the year 2000...and beyond...still emphasizing quality coverage, appropriate rate levels, strong loss reserves, and the finest available claims service.



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Funding Education After Tax Reform

By John E. Sestina
SMB Financial Planning Inc.

According to *U.S. News & World Report* November 17, 1986, the average cost of one year at a private college (including tuition, room and board, fees, transportation, books and supplies) will be $12,511 in 1988-89. Other information concludes education costs are rising at a significantly higher rate than inflation. Doctors continue to desire to provide the "best" education they can for their children. But new tax laws have made some of the old favorites useless, as well as affected their future effectiveness. As a result, it is more important than ever to plan for your child's education.

When planning for some future cost such as education, it is always important to make decisions based on economics rather than taxes. Do not let the tax tail wag the economic dog. First of all, with a lowering of tax brackets it may no longer be advantageous to shift income-producing assets to your child. You will have to examine this on an individual basis with your tax adviser. Also remember if your child is under 14, he is taxed at your rate on unearned income. There is an exemption for $1,000 of this income. The first $500 is tax free and the next $500 is taxed at your child's bracket. Finally, if your child has an income of more than $17,850, he is in the same tax bracket as you whether he is 14 or older.

It is also important to plan sooner rather than later. As chart 1 indicates, inflation will raise the current $12,511 annual cost to $33,689 in the year 2004 if inflation continues at only 6%. Each year the cost will continue to rise for a total cost of $147,378 for just one child. Assuming your federal and state combined tax bracket is 40%, you will have to earn $245,630 to fund this cost if you wait to pay it as you go. On the other hand, if you begin now, your total cost will be $68,775. Before taxes you would have to earn $114,625. You would reduce your cost by $131,005 before taxes by starting now in this illustration. If you could arrange for your child to receive a lump sum of $32,798 today, that lump sum would be sufficient to pay the projected costs in this illustration. That would only be a before-tax cost of $54,663. Sooner is always better.

Although taxes are not the main issue, it is still necessary to pay attention to them in light of funding your child's education. After all, if you reduce the taxes, you can reduce the overall cost. There are still many things you can do to keep the taxes reasonable.

You can still make gifts. The gifts must be permanent and cannot revert back to you or your spouse.

You can direct your child's portfolio so as to purchase those investments which do not produce taxable income at this time. Such investments as growth stocks, tax exempt bonds, Series EE bonds, land and certain insurance policies do not produce taxable income. From the point of view of control these investments also offer another advantage. You can own

EDUCATION PLANNING

CHART 1

Inflation		6%
Investment Return		8%
Percent of cost to pay		100%
CHILD		Michael
AGE		1
YRS TO ATTEND		4
PRESENT INVESTMENTS		0
TODAY'S COST		$12,511
YRS TO ENTRY		17
YEAR OUT		22
LUMP SUM		$32,798
1	1987	0
2	1988	0
3	1989	0
4	1990	0
5	1991	0
6	1992	0
7	1993	0
8	1994	0
9	1995	0
10	1996	0
11	1997	0
12	1998	0
13	1999	0
14	2000	0
15	2001	0
16	2002	0
17	2003	0
18	2004	$ 33,689
19	2005	$ 35,711
20	2006	$ 37,853
21	2007	$ 40,124
TOTAL		$147,378

them until you are sure of your child. Since these items are not currently taxable, there may be no advantage to bestowing them on your child until he needs them. At the time of the gift, there is no tax to you. When your child subsequently sells the asset, he pays tax at his bracket. Obviously, he should be older than 14.

You can still use trusts. The Clifford trust is gone for all practical purposes, but you can still set up a trust that can accumulate income. The first $5,000 of trust income is taxed at 15%. You can provide for the trustee to accumulate and distribute income. When there is income in excess of the $5,000, that income could go to the child. You will note in Chart 2 that should you save the $3,275 per year, the interest exceeds $5,000 per year around the age of 14.

CHART 2

		Present Investments	Save Per Yr.	Need	Remainder	Interest
1	1987	0	3,275	0	3,275	262
2	1988	3,537	3,275	0	6,812	545
3	1989	7,357	3,275	0	10,632	851
4	1990	11,483	3,275	0	14,758	1,181
5	1991	15,938	3,275	0	19,213	1,537
6	1992	20,750	3,275	0	24,025	1,922
7	1993	25,947	3,275	0	29,222	2,338
8	1994	31,560	3,275	0	34,835	2,787
9	1995	37,622	3,275	0	40,897	3,272
10	1996	44,168	3,275	0	47,443	3,795
11	1997	51,239	3,275	0	54,514	4,361
12	1998	58,875	3,275	0	62,150	4,972
13	1999	67,122	3,275	0	70,397	5,632
14	2000	76,029	3,275	0	79,304	6,344
15	2001	85,648	3,275	0	88,923	7,114
16	2002	96,037	3,275	0	99,312	7,945
17	2003	107,257	3,275	0	110,532	8,843
18	2004	119,375	3,275	33,689	88,960	7,117
19	2005	96,077	3,275	35,711	63,641	5,091
20	2006	68,733	3,275	37,853	34,154	2,732
21	2007	36,887	3,275	40,124	37	3
	TOTAL COSTS		68,775	147,378		

You can control the amount of income a piece of property generates to your child. Suppose your child is leasing a piece of equipment to your corporation. You can have an increasing rent per month to coordinate with your child's age. You will need competent tax advice on this idea.

You can employ your child. The pay must be reasonable, of course. With this method, you do not have to worry about your child being younger than 14 as far as the kiddie tax is concerned because a child can earn any amount. The taxation at your bracket applies only to unearned income. Your child can be employed to take phone calls, file correspondence, deliver documents, clean your office, etc.

You can transfer the rights to income to your child. Suppose you are writing a book or article and expect to be able to sell it. Before you consummate the same, it is possible to give the rights in that book to your child. Then your child receives the taxable income from the project.

You can lend your child $10,000 for college. As long as he does not use the income to acquire income-producing property, and as long as college tuition is the primary reason for the gift-loan, there are no income tax consequences. He uses the money for college and in five years or so repays you.

You can take a second mortgage or a home equity loan. This interest can be deductible and help reduce the education cost.

You can have a sideline business in which the children are part owners. The business structure will depend on the type of business it is. Your options are limited partnership with you as the general partner and your child as the limited partner. This may work if the business is the management of real estate, for example. You may have an S corporation if you have a service-oriented business in which you are not actively engaged. You must have a regular corporation if your business was one in which you performed all the services.

Your child could earn the money

continued on page 710

Ohio Supreme Court applied in this ruling the medical malpractice statute of limitations unconstitutional could very well be applied to similar statutes for nonmedical liability cases. We will be actively contacting business and professional groups such as architects, engineers, manufacturers and others who currently have the protection of statutes of limitations to enlist their support in the Legislature and in communities across Ohio in opposition to the Ohio Supreme Court ruling.

5) **Political activity** — All of us in Ohio must recognize that the members of the Ohio Supreme Court are elected officials. **The individuals who currently sit on the Ohio Supreme Court all must run for reelection to the Court. Individual physicians, auxilians and the citizens of Ohio who are adversely affected by this Court's ruling must work aggressively to remove the Justices of the Ohio Supreme Court who concurred with the opinion.** Our adversaries, the Ohio Academy of Trial Lawyers and the Nader type groups in Ohio will certainly attempt to retain the current Court with active support in the form of money and campaign workers. **The issues here are not Republican or Democrat but issues of philosophy of the members of the Supreme Court. We must make every effort collectively through the Ohio Medical Political Action Committee and individually as practicing physicians and auxilians to change the philosophy of the Court by electing new Justices.** These type of rulings by "Judicial fiat" which ignore the sound public policy decisions of the Legislature cannot be accepted. We must **redouble our efforts in contributing to OMPAC and our individual political involvement** in the election of members of the Ohio Supreme Court who will act responsibly for the benefit of the citizens of Ohio. As well, we must work to support legislators and candidates for the Ohio General Assembly who seek to maintain access to cost effective, quality health care services for the citizens of Ohio.

As you can see, the challenges that face the OSMA and we as practicing physicians are greater everyday. Yes, it does seem that our struggle on behalf of our patients is shrouded with adversity. However, we have an opportunity to be a positive factor for the benefit of our patients. I have outlined an action plan that you will hear a great deal more about in the coming weeks and months to deal with this crisis that has been created by the Ohio Supreme Court. **Together, OSMA and physicians working together, effectively communicating with our patients and decision-makers can deal with the challenges and opportunities that lie ahead. I believe that we must TAKE CHARGE FOR A CHANGE.**

CONTINUING MEDICAL EDUCATION

October

5TH ANNUAL NEONATAL CONFERENCE — "NEONATAL POTPOURRI":
When: October 16, 1987; Where: Hyatt Regency/Ohio Center, Columbus, Ohio; Credits: available; Fees: $65; Sponsor: Children's Hospital, Columbus; Contact: Program Coordinator, Department of Education, Children's Hospital, 700 Children's Drive, Columbus, Ohio 43205 — (614) 421-2245.

SCHOOL DAZE: CHILDREN'S SCHOOL AND ATTENTION PROBLEMS:
When: October 30, 1987; Where: Children's Hospital, Columbus, Ohio; Credits: CME and OAFP credit available; Fees: $20; Sponsor: Children's Hospital; Contact: Program Coordinator, Department of Education, Children's Hospital, 700 Children's Drive, Columbus, Ohio 43205 — (614) 421-2245.

Fulton Memorial Lecture

When: October 20, 1987
Where: Riverside Hospital Columbus, Ohio
(for details, see page 673)

November

Clinical Application of Computer Technology to the Delivery of Patient Care

When: November 5-7, 1987
Where: Bunts Auditorium Cleveland Clinic 9500 Euclid Avenue Cleveland, Ohio
Credits: 18 hours, Category I
Fee: $275
Sponsor: The Cleveland Clinic Educational Foundation
Contact: Department of Continuing Education The Cleveland Clinic Educational Foundation 9500 Euclid Avenue Cleveland, Ohio 44106 1 (800) 762-8172 (in Ohio); 1 (800) 762-8173 (outside Ohio)



Thomas R. Leech, MD, OSMA's new Membership Committee Chairman, practices plastic surgery in Gallipolis.

New Membership Chairman Appointed

By David Sweet

Membership growth is important to any organization, but growth is vital to all medical organizations, says Thomas R. Leech, MD, the new chairman of OSMA's Membership Committee.

Dr. Leech, also OSMA Third District Councilor, took over the reins of the Committee when Thomas W. Morgan, MD, of Gallipolis, stepped down after seven active years as chairman. "One of my main goals is to get accurate information regarding both members and non-members," says the Lima plastic surgeon. "We would like to increase membership to include all members of the profession, regardless of their status in the communities, whether they are on a teaching staff, retired or new physicians in town."

The problem with identifying non-members is evident to Dr. Leech when he looks at the current membership rosters of his own county society. "I see names of people who haven't been around for a year or two on those lists — no wonder they haven't paid dues, they're not there." Physicians are a very mobile population, and some societies have trouble tracking their movements. Dr. Leech thinks many counties are unsure of the accuracy of current data on members and non-members.

"I think we need a better physician tracking system," Dr. Leech says. "Part of this is going to require a liaison between the Membership Committee, the staff and the county officers and executives." Data which includes the names of all doctors in the county, whether they are OSMA or AMA members or not, should be current and available to all county societies for retention and recruitment purposes, Dr. Leech advises.

"We need an outreach program that will get physicians started as soon as they enter a community," he says. The ideal time to do this, says Dr. Leech, is when a physician applies for hospital privileges after finishing a training program. "We need to have our files up-to-date, in order to carry out any kind of a calling program and avoid calling physicians who

"You join the OSMA to make medicine an active way of life — to preserve medicine for medicine."

are no longer there.

A past president of the Allen County Medical Association, and recently-announced candidate for President of the OSMA, Dr. Leech has been involved in organized medicine for nearly 30 years. He is optimistic about the OSMA's new Membership Outreach Program, which brought 128 new OSMA members into the fold in 1986. "Dr. Morgan has started a very interesting program which is beginning to show benefits," Dr. Leech notes. "We must continue with his program, but we must also keep looking for ways to strengthen it. I don't want to tear it apart, I want to build on it."

The second major project that Dr. Leech wants to tackle is a demographical analysis of the 4,000 to 5,000 block of non-member physicians in Ohio. "We need to categorize them and see if there's a trend or commonality among them," Dr. Leech says. "I keep hearing, for instance, that the foreign medical graduates are non-participants, and yet, when you look at the statistics, the FMGs are highly participatory."

Who *are* the non-member practitioners in Ohio? Dr. Leech believes they are doctors from just about every category. "We sense that a lot of the Ohio-licensed non-members are teachers or researchers. Many of them don't practice." He urges these physicians to become a part of organized medicine, rather than isolating themselves from the rest of their colleagues.

"As a physician, I hope that besides teaching, I'm taking care of people. If I'm doing that I would want to be a member in organized medicine," Dr. Leech says.

Dr. Leech thinks that physicians owe it to the profession of medicine to belong to organized medical societies. "You join the OSMA to make medicine an active way of life, to preserve medicine *for* medicine — away from the inroads made by third-party payors and the federal government," he states.

Only by federation is strength acquired, Dr. Leech believes. When it comes to AMA participation, Dr. Leech says Ohio is doing a good job, as AMA membership is better than 70%, compared to just over 50% nationwide. "We need to do a better job to increase that active participation," Dr. Leech says.

He is a bit disappointed with Ohio participation in OMPAC and AMPAC, the political action committees of the OSMA and AMA. "Why should we have a 12% to 17% participation? That's a pretty low participation index," Dr. Leech comments. "People need to know that they have to be active. If they're going to help themselves, they've got to know *how* to help themselves." This is where organized medicine comes in.

At the OSMA Annual Meeting in May, two resolutions were proposed to create special categories for women in medicine and for foreign medical graduates. Both were defeated by the House at their requests, Dr. Leech recalls. "They do not want to be treated differently, they want to be treated as equal members of the OSMA. I agree with that." He believes each Ohio physician should be treated equally, regardless of their sex or where they went to school.

Although a certain percentage of physicians will never join organized medicine, Dr. Leech concedes, the committee needs to focus on getting the attention of the non-members. "Many physicians don't join because they don't feel there is a need for their participation. This is why we need to make an effort to educate these doctors."

As far as programs and other special efforts to get non-members to join, Dr. Leech thinks that the OSMA has done an excellent job of offering incentives for membership. He cites reduced fees for students, residents and retired physicians in addition to benefits from PICO, as valid reasons for physicians to join the OSMA.

Of course there are other reasons as well. The OSMA is sincere about wanting to meet the needs of physicians around the state, Dr. Leech notes, but if you don't want to participate — "how are we going to help you? We won't know your problems if you're sitting there by yourself."

Dr. Leech hopes that many of the non-member physicians of Ohio will agree that the advantages of OSMA membership far outweigh the disadvantages. "It's hard to come up with disadvantages," Dr. Leech concludes. **OSMA**

NEW MEMBERS

ALLEN (Lima unless noted)
Edward B. Blackmon, Jr., MD
Anne Michele Pike, MD

BELMONT
Wayne E. Groux, MD, Zanesville
Bernardino D. Marcelo, MD, Moundsville

COLUMBIANA
Lawrence K. Wacaser, MD, E. Liverpool

CUYAHOGA (Cleveland unless noted)
Jamal A. Almobayyed, MD
Rashda Firdaus, MD, Strongsville
Fuad Jubran, MD
Margaret A. Kravanya, MD
Danh V. Le, MD
D.K. Menyah, MD
Dalmacio L. Miranda, MD
Nezar Rahim, MD
Richard A. Rudick, MD
John P. Sevastos, MD

FRANKLIN (Columbus unless noted)
Christopher O. Baldwin, MD
Donna Lee Hosmer, MD
David F. Huber, MD, Westerville
Diana Michele Johnson, MD
James Randall Kerbs, MD
Richard Mayron, MD
Thomas Jay McMurray, MD
Ellen J. Offutt, MD, Westerville
Jose A. Ottaviano, MD
Ronald Gerard Pirrallo, MD
Merit Sarah Rome, MD, Worthington
Katherine Swan Rutherford, MD
Todd Lowell Sobel, MD
Richard Strauss, MD
Maria Josephine Sunseri, MD, Dublin
John F. Tugaden, MD

GALLIA
Montrie Chaksupa, MD

HAMILTON (Cincinnati unless noted)
Wayne C. Amendt, MD
Don Lee Bradke, MD
Bruce C. Corser, MD
Truddie R. Edwards, MD
Ann B. Fischer, MD
Jerry A. Friemoth, MD
Elmer Martin, MD
Andrew B. Minkin, MD
Richard T. Sheridan, MD
Marshall G. Vary, MD

HANCOCK
Robert L. Hillery, MD, Findlay

HURON
Woo H. Paik, MD

KNOX
Ronald C. Huhn, MD, Mt. Vernon

LAKE
John V. Cady, MD, Painesville

LUCAS (Toledo unless noted)
Wesley W. Kinney, MD
Richard D. Sbrocchi, MD

continued on page 710



Ask the Ombudsman

Q. *— Medicare claims for railroad retirees administered by Travelers Insurance are often reimbursed below the Medicare allowable amount for Ohio. I am a Medicare participating physician, and I signed a contract with Nationwide Insurance. Am I required to accept this lower amount from a carrier located in Georgia?*

— MD, Columbus

A. — The Medicare participating agreement applies to ALL Medicare enrollees. However, OSMA learned that Travelers in Augusta, Georgia, which administers Medicare for railroad retirees in fifteen states, including Ohio, may not always have available current physician profiles for Ohio physicians and lower amounts may be incorrectly reimbursed. We suggest . . . rebill incorrectly reimbursed claims to:

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Medicare Medical
Review Department
P.O. Box 10066
Augusta, Georgia 30999

Include a current example of an Ohio Nationwide Medicare EOMB for the same service which reflects the correct allowable amount.

Q. *— The Medicare MAAC sets exact amounts I am permitted to bill my Medicare patients. I still am not clear on how to bill multiple surgical care, especially when a surgical case is more complicated than usual.*

— MD, Dayton

A. — Medicare claims involving unusual and

continued on page 726

County Society Roster Changes

ALLEN: David B. Steiner, M.D., President, 1220 E. Elm St., #110, Lima 45804-2818.

BUTLER: Alvin H. Niemer, M.D., President, 50 N. Breiel Blvd., Middletown 45042-3804; Scott Zollett, M.D., Secretary-Treasurer, 28 S. Clinton, Middletown 45042-4172; Badonna Reese, Executive Secretary, 111 Buckeye St., P.O. Box 3216, Hamilton 45013, 513/893-1410.

CUYAHOGA: Wilma F. Bergfeld, M.D., President, Cleveland Clinic, Desk A-61, 9500 Euclid Ave., Cleveland 44106-4712.

FRANKLIN: Claire V. Wolfe, M.D., President, 5521 Indian Hill Rd., Dublin 43017-9709.

HAMILTON: K. William Kitzmiller, M.D., President, 9500 Kenwood Rd., Cincinnati 45242-6140; Clyde E. Henderson, M.D., Secretary, 3333 Vine St., Ste. 700, Cincinnati 45220.

KNOX: Robert E. Rodstrom, M.D., President, 812 Coshocton Ave., Mount Vernon 43050-1947; Terry P. Barber, M.D., Secretary-Treasurer, 136 Mill St., P.O. Box 483, Utica 43080-0483.

LAKE: Jeffrey Siminovitch, M.D., President, 8224 Mentor Ave., Mentor 44060.

MARION: Paul Deringer, M.D., President, 1040 Delaware Ave., Marion 43302-6416.

VAN WERT: Terrence L. Johnson, M.D., Secretary-Treasurer, 140 Fox Rd., Van Wert 45891-2440.

WASHINGTON: William C. Grosel, M.D., Secretary-Treasurer, 27 Tecumseh Dr., Marietta 45750-9630.

WOOD: Robert G. Neville, M.D., President, 960 W. Wooster St., Ste. 207, Bowling Green 43402-2646; Jose Guerra, M.D., Secretary-Treasurer, 3227 Shakespeare Lane, Toledo 43615-1653.

New Members . . . *continued*

MIAMI
Joon Koo Yeo, MD, Troy

MONTGOMERY
Richard Scott Elloway, MD, Dayton
Charles Gardner, Jr, MD, Dayton
Victor W. Lee, MD, Kettering
Kevin David Neese, MD, Kettering
Douglas Lee Pinto, MD, Dayton
James J. Schlesinger, MD, Dayton

STARK
Elizabeth Baum, MD, Canton
Jeffrey Kaplan, MD, Canton

SUMMIT (Akron unless noted)
Robert A. Felter, MD
John Fink, MD
Andrew J. Kurman, MD
Jose C. Rafecas, MD
Thomas R. Thompson, MD

Financial . . . *continued*

himself. Many individuals have paid their own college expenses and turned out none the worse. Some even conclude it offers a better appreciation for the education.

Space does not permit all the possibilities, but clearly, there are many things you can still do to provide for your child's education in the least expensive manner possible.

John E. Sestina is a vice president with SMB FINANCIAL PLANNING, INC., a member of the PICO Financial Services Group which provides specialized financial planning services to physicians and other professional individuals and corporations on a fee-only arrangement.

BOOK REVIEW

Stop Smoking

By Jim Liles, MSW; Vantage Press Inc.; 45 pages; $7.95

This short book has two subtitles, "How to Help Yourself and Those You Love" and "A Helping Professional's Guide to Stopping Smoking." In this short book, the author outlines a program for assisting individuals to stop smoking utilizing a single session hypnosis treatment. He begins by discussing both the difficulties in stopping smoking as well as the objections that smokers may have to stopping. He also gives suggestions to be used during hypnosis for ensuring abstinence. In an attempt to cover smoking cessation from the view point of the professional and the smoker in a single short publication, the author does not fully satisfy either audience.

In his first chapter he discusses addictive thinking. Although this may be helpful for smokers to assist in stopping smoking, this is not a generally accepted idea among addictionologists or psychiatrists. What we know is that tobacco users become addicted to nicotine. It is hard to break that addiction cycle because of withdrawal symptoms and using the addicting chemical helps a person feel normal. He comes close to describing some of the affects of using an addicting drug on page 5 when he says "cutting down intensifies the pleasure of each cigarette." What happens is, if an addict fails to maintain a fairly uniform blood level of the addicting chemical then blood levels will fluctuate widely. Consequently, the "high" experience from each individual fix will be more intense. That certainly is the case with nicotine as with any other drug. This phenomena is especially evident for short-acting drugs like nicotine.

The third chapter, "The Therapist Prepares for War," is probably his best chapter. It tells therapists how they might confront a smoker to help them stop smoking. From then on, the book is primarily a therapist's guide for someone without much experience in helping a smoker stop. Although it is a useful guide, it is probably no better than the earliest publication on single session treatment for smoking that I am aware of — Herbert Speigel's (1970) "A Single Treatment Method To Stop Smoking Using Ancillary Self-Hypnosis," *International J. Clinical and Exp. Hypnosis;* page 235-250.

The book concludes with several order forms to order audio tapes for smoking cessation. This suggests that the book is to be used in conjunction with public lectures. Indeed, the fly leaf says "At the time this book was written, he (Liles) was conducting weight loss and non-smoking seminars for business and recreation departments in over 25 cities."

Hypnotherapy programs are an effective approach for smoking cessation for those individuals who find that an organized smoking cessation treatment is necessary. However, approximately 95% of those who quit, do so on their own at the suggestion of their physician or at their own behest. Studies of smoking cessation programs have found that those that provide reinforcement after the program have been most successful. This short book provides that reinforcement with tapes for $12.95. Other approaches for reinforcement teach the patient to engage in self-hypnosis.

Jim Liles and many others tend to ignore that smoking appears to involve two very distinct habits. One of these is the addiction to nicotine, which is physiologic with physiologic withdrawal symptoms. The second habit is more psychological and one which I usually call "fondling." This involves the manipulative behavior surrounding a cigarette, placing it in one's mouth, etc. This behavior is even more pronounced in pipe and cigar smokers. Therefore, it is frequently useful to separate the two behaviors and assist the smoker in withdrawing from them one at a time. Mr. Liles does not mention this. One approach uses nicotine gum, in which the fondling behavior is stopped and the nicotine behavior is continued; and the nicotine is gradually withdrawn. Other approaches have been those in which smokers have found the necessity for substituting lollipops, candy cigarettes, carrot sticks, etc. for cigarettes, thereby terminating the nicotine habit but continuing the fondling behavior. The fondling behavior is then gradually discontinued.

The increase in appetite seen with stopping smoking is probably the combination of two effects. Nicotine, because it is a mild stimulant, mildly supresses appetite; and there is a rebound increase of appetite after nicotine is withdrawn. However, fondling behavior continues and consequently there are two drives to continue eating after stopping smoking. One way of helping is to substitute a low calorie object for the cigarette such as carrot sticks.

Because of devastating long-term health problems associated with smoking, all efforts to decrease the number of smokers is welcomed. Unfortunately, the book does little to increase our ability to assist smokers in stopping, except to the extent that it probably serves as a reinforcement for those attending Jim Liles' treatment sessions.

Martin Macklin, MD, Ashtabula, Ohio.

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The Medical Student Section of the OSMA

By Derrick D. Jeter, President

The Medical Student Section of the OSMA exists to provide student participation in the activities of the OSMA and the AMA. This has been accomplished by allowing students meaningful input into the decision and policymaking process of the OSMA and AMA; initiating and effecting necessary changes on issues affecting our profession; improving medical education; and providing a forum for the discussion and dissemination of information relevant to medical students.

Over three thousand medical students in Ohio are members of the OSMA and are represented in the OSMA by the Medical Student Section Governing Council. The Governing Council consists of the President, Vice-President, Secretary, Delegates from each Ohio medical school and an Alternate Delegate to the AMA. These individuals act on behalf of the MSS constituency throughout the year. They monitor student interest, product resolutions and develop organizational and programmatic initiatives.

Traditionally, past MSS Governing Councils have established their own short and long-term goals and objectives at the onset of their tenure in office. These goals are derived from the wishes of the MSS assembly and other opportunities identified by OSMA staff and local MSS leaders. This year, the MSS will focus its energy on promoting medical student research, conducting medical student impairment program survey, beginning to implement the Student-to-Student Health Education program as a statewide program and increasing medical student participation in the OSMA.

There are many issues facing medical students today — the cost of medical education, medical student impairment, competition for residency slots, the changing structure of the medical practice environment and the direction of medical education for the future. The way we can face all of these dynamic changes occurring in our profession is to utilize organized medicine as our voice to legislators and other policymakers that create initiatives that affect medical students and our profession.

Organizations like the OSMA and AMA act as physician and patient advocates to protect the rights of physicians and patients in the changing environment of health-care delivery today and in the future. On behalf of the OSMA-MSS, we are here to serve you. **OSMA**

Derrick D. Jeter is a third-year medical student at Wright State University's College of Medicine.

Recent Advances in Diagnostic Radiology

By James D. Curry, MD

Amazing discoveries in the technologic area of diagnostic radiology continue to confound us all. Those who have finished residency training 10 or more years ago find themselves utilizing skills (more often than not) that were acquired since residency training. Perhaps most striking of the new developments is the CT scanner. It seems like only yesterday when neurosurgeons struggled valiantly with limited tools to diagnose intracerebral catastrophes using cerebral arteriograms and pneumoencephalograms to help arrive at a diagnosis. To tell the neurosurgeon today that the CT scanner is "down" brings about a response closely akin to the reaction to the loss of one's fortune or the burning down of one's home! Continued advances are also seen in the practical development of digital subtraction angiography, a tremendous increase in variety of interventional procedures and the impressive progress in the development and use of magnetic resonance.

All of these refinements are too numerous to mention in detail in this brief report. However, it is the purpose of this discussion to mention some of the more impressive and more significant examples of change which already have had their impact on patient care — or probably soon will. The major areas reported will include magnetic resonance, computed tomography, ultrasonography, interventional radiography and nuclear medicine.

With the development of faster scan time in MR and the ability to image blood pools separately from cardiac chambers and the use of cine MR, the evaluation of cardiac defects and ischemic heart disease has been improved. New techniques permitting systolic and diastolic gaited images have presented a new and promising method of non-invasive arterial imaging.[1]

Ongoing studies comparing MR with CT have shown that MR is superior to CT in the detection of subacute injuries of the brain through the use of T1- and T2-weighted images. The non-hemorrhagic results of trauma have been proven to be much better visualized by MR than by CT. This includes shearing injuries, contusions and infarction. These findings are helpful when related to late patient decline following trauma, frequently when CT can't explain the worsening signs.[2,3] Further evaluation of brain lesions utilizing MR includes evaluation of midline structures, leukoencaphalopathies, and numerous other specific areas of disease processes. The diagnostic capabilities of MR are being proven almost limitless in the evaluation of the spine. Some recent studies have shown that MR is at least the equivalent to CT in the evaluation of herniated lumbar discs.[4]

As the advances in MR technology continue, the orthopedist stands to gain considerably. In evaluating the extent of primary bone and soft tissue tumors, MRI was judged superior to CT.[5] MR has proven also to be the most sensitive method of detecting early avascular necrosis of the hip.[6] Evaluation of knee injuries and disease conditions is also being investigated and promises a great potential for the future. Stress factors have been evaluated. Among numerous other areas relating to orthopedics are the evaluation of rotator cuff tears, aneurysmal bone cysts and other bony tumors.

Investigations are being made in numerous other areas of the body including the laryngeal area, chest, abdominal organs and most interesting and promising, studies relating to the pelvis.

But for all the advances in MR, its cost and lack of speed so far have tended to limit its overall usefulness. CT, therefore, has managed to remain paramount in general body imaging. Further refinement in the studying of disease processes have made CT of ever-increasing value. In addition to improved evaluation of cerebral tumors, CT has become valuable in the stereotactic evaluation of

"Further refinement of ultrasound equipment and imaginative exploration of sonographic potential has sparked many interesting developments . . ."

deep brain lesions, which can be biopsied more easily, occasionally resected and even implanted with local radioactive therapeutic agents. Advances in 3D-CT imaging have been tremendously helpful in preparing surgeons for surgical restoration of cranial, facial and pelvic injuries. In spite of the advances in cardiac MR, cine CT (although not widely available) is still preferred overall in evaluation of cardiac problems. It has also proven helpful in screening airway obstructions including vascular rings, tracheomalacia and laryngomalacia. Improvement in the staging of bronchogenic carcinoma and evaluation of lung nodules have also made progress. Better ability in terms of densitometry have been achieved particularly in relationship to chest nodules.[7] Evaluation of thoracic lymphomas as well as some of the pneumoconioses has also been quite helpful and successful. With refined software, it is now possible to obtain precise and quantitative evaluation of bone mass therefore providing a method of following osteoporotic states. With the increasing number of older individuals, particularly women, who have severe osteoporosis, quantitative CT should have significant impact as it is brought further into use.[8]

Further refinement of ultrasound equipment and imaginative exploration of sonographic potential has sparked many interesting developments. Intraoperative use of ultrasound is now in its infancy but developing rapidly and in many instances it makes the neurosurgeon's job much easier, delineating abnormal areas, particularly in the brain. The development and refinement of two-dimensional echo techniques for the heart and vessels has the advantage of being non-invasive without biological effect. Evaluation of the fetus and its abnormalities has been improved; precise fetal dating has become a reality. Intracavitary sonography (with special reference to evaluation of gynecologic, urologic and rectal diseases) is being investigated and has proven, at times, very helpful.[9]

Exquisite evaluation of intrafetal anatomical areas has been perfected so that evaluation of normal and abnormal processes or areas of development can now be studied in detail in the fetus. Small amounts of peritoneal fluid (10-15 cc) in fetuses of 22 to 26 weeks gestation has been demonstrated.[10] Almost all organ parts of the fetus have been or are in the process of being studied. The increasing use of ultrasound in guiding invasive procedures relating to the urinary tract and abscesses has been observed. Some additional comment relating to these uses will be made under the topic of interventional radiology. Further significant advances in the field of ultrasound are expected and eagerly anticipated.

Second to the development of CT and MR, the expansion of the field of interventional radiology is astounding. The increased emphasis in the area of residency training heralds an even greater expansion in this area. With the proliferation of extracorporeal shockwave lithotripsy (ESWL) the frequency of the radiologists performing percutaneous procedures to extract urinary calculi may level off somewhat. However, this procedure and other urologic procedures guided by the radiologist have become most important in patient management in recent times. Though endoscopic means may be replacing percutaneous transhepatic bowel drainage to some extent, this is still an important area. Percutaneous drainage secondary to liver trauma and abscesses are becoming more common with improved imaging. Percutaneous transluminal angioplasty (PTA) has progressed greatly from dilatation of stenoses in the vessels of the extremity to more delicate areas — the carotid and coronaries. In recent months, we have learned the importance of proper patient selection when doing these procedures. Though the necessity of redilatation of coronary vessels is not uncommon, this procedure does offer a significant alternative to coronary bypass surgery. The development of improved catheters and guides, means of increased oxygen perfusion and other new techniques have all contributed to the increased use of PTA.

Another promising area being utilized relates to transcatheter embolization — particularly in areas where acute bleeding can be stopped and preoperative bleeding reduced. Complications in this field can be serious and include cerebral embolic phenomenon, necrosis and infection.[11] The use of intracranial embolotherapy has also employed detachable balloons

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for the treatment of aneurysms. A similar procedure is now being used in the treatment of carotid carvenous sinus fistulas.[12] Chemical embolization has been used in the treatment of spinal cord AVMs.

Although playing second fiddle to developments of CT and MR, nuclear medicine is now undergoing a resurgence with significant developments. Some of these developments are strictly relegated to the larger centers, due to the need of a cyclotron for production of very short-lived radionuclides. Among the more successful of these is the advancements in positron emission tomography (PET). These procedures can be of help because they help quantitate changes in body tissues and thus help make diagnostic images more valuable. Evaluation of stroke, epileptic disorders and other cerebral dysfunctions are aided through the use of PET. Because of the development of single photon emission, (SPECT), cerebral blood flow reflecting function rather than morphology has been more easily evaluated.[13,14]

Thallium 201 Myocardial Scanning is not a brand-new development. However, with improved scanning techniques, cardiologists have become more dependent on this study. Frequently, it is used as an excellent screen for ischemic heart disease and oftentimes reduces the urgency of invasive coronary arteriography.

Improvement in instrumentation and development of new radiopharmaceuticals promise continued improvement and advancement in the use of nuclear medical pursuits.

This article has touched briefly on some major developments in magnetic resonance, computed tomography, ultrasonography, interventional radiology and nuclear medicine. Other advancements include the

development of the low osmolality and non-ionic contrast agents and the burgeoning development of digital radiography. These are having an impact on the practice of radiology and no doubt will contribute more in the future.

Indeed, in all areas, the improvements and advances continue to make the practice of diagnostic radiology worthwhile and exciting. The challenge remains for us, however, to utilize these tools efficiently and in proper sequence with our final goal being the optimal welfare of the patient.

James D. Curry, MD, is a radiologist, practicing in Mansfield.

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AIR FORCE

AORTOCORONARY BYPASS IN PATIENTS UNDER AGE 65: EXPERIENCE IN 605 CASES

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Aortocoronary bypass was carried out in 605 patients under age 65, with a major nonfatal complication rate of 7.9% and an operative mortality of 1.3%. Among surviving patients, 81% were in functional class I and 90.7% returned to previous employment post-operatively. Advances in operative therapy for ischemic heart disease have kept pace with increased demands.

Introduction

After almost two decades of use, aortocoronary bypass remains the most commonly employed effective treatment for severe coronary artery disease. Advances in anesthetic, surgical techniques and sophisticated perioperative care have made such procedures quite commonplace and safe in larger centers. Despite the increasing age of our population and the tendency for more elderly candidates to be referred for operation, the majority of our patients still fall within the pre-retirement age group. Because such patients look forward to future years of active life and employment, aggressive interventions are often recommended.

In a retrospective review of 1,000 consecutive patients undergoing open heart surgery by our group at the Mount Carmel Medical Center in Columbus, 605 patients under 65 years of age underwent aortocoronary bypass in the interval of January 1983 to November 1985. This report analyzes our operative experience in this distinct subgroup of patients.

MATERIALS AND METHODS

As noted previously,[1] criteria for patient selection and operative and perioperative care were standardized, regardless of age. Indications for operation included evolving myocardial ischemia, unstable angina, angina not responding to maximal medical therapy and left mainstem coronary disease or its anatomic equivalent. Virtually all such patients were accepted for operation in the absence of medical contraindications or severe and

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irreversible impairment of ventricular function. Sites selected for grafting were based on both cardiac catheterization and intraoperative findings, with bypass of all major vessels and their larger tributaries with greater than 50-60% narrowing of luminal diameter. All procedures were carried out using standard cardiopulmonary bypass, systemic hypothermia to 28° centrigrade, topical ice slush irrigation of the pericardial cavity, and cold potassium cardioplegia. Complete revascularization was carried out in each patient using autogenous saphenous vein or internal mammary artery grafts. Perioperative care was routine and included antiplatelet agents initiated prior to operation whenever possible. Follow-up data were obtained each instance.

RESULTS

Among the 605 patients, there were 509 men (84%) and 96 women (16%). Mean age for the group was 54.4 years, with a range of 36 to 64 years. A mean of 3.1 grafts per patient was performed (range 1 to 8) and associated coronary endarterectomy was carried out on 63 occasions. The left internal mammary artery was utilized for revascularization of the anterior descending coronary artery in 22 patients, with saphenous vein grafts being used in all remaining instances. Twenty-seven patients had undergone previous cardiac surgery. Percutaneous transluminal coronary angioplasty (PTCA) had been carried out on a cardiology service in 63 patients an average of 20 days prior to operation; a total of 815 PTCA procedures were performed at our institution during the same time period.

Major nonfatal complications occurred in 48 instances (7.9%), requiring additional operative intervention or prolongation of hospital stay; most common were pulmonary problems (19 cases), hemorrhage with tamponade (15 cases), vascular emergencies (six cases), and sternotomy wound infection (five cases). There were eight hospital deaths, for an overall operative mortality of 1.3%. Patients who did not survive were characterized by having recent cardiac catheterization, PTCA, or acute myocardial infarction prior to operation; six of eight deaths were directly attributed to cardiac causes (Table I). Hospital stay (date of operation to discharge) ranged from seven to 50 days, with a median stay of 10 days.

Late follow-up by means of periodic office visits or telephone contact was obtained in all 597 operative survivors. Average follow-up was 30 months (range 14-48 months), with 23 late deaths; 81% of surviving patients were in functional class I when last contacted. Among 498 patients who were actively employed prior to operation, 452 (90.7%) returned to work postoperatively.

DISCUSSION

In contrast to our older patients undergoing aortocoronary bypass during the same time period,[1] the relatively young patients in the present series show a greater male predominance, a much higher frequency of previous angioplasty, and an average requirement for fewer bypass grafts. Cause of death, however, was most commonly cardiac-related in all age groups, a finding which has been well established by others.[2-3] Among nonsurvivors, the notable presence of high risk patients, namely those undergoing recent cardiac catheterization, PTCA, or acute infarction, is again substantiated. This admixture is by no means unique to the present patient population, and our operative mortality of 1.3% is certainly in accordance with reports from other large centers.[4-7]

Despite commendable results in our younger patients, the overall risk of surgical myocardial revascularization should be expected to rise. Several reasons account for this trend. Younger patients, presumably with less advanced coronary disease, are initially being placed in the medical or angioplasty pool, thereby changing the composition of the population referred for surgical treatment. Aortocoronary bypass is, therefore, often a court of last resort, being reserved for the elderly or for young patients with advanced disease or in whom previous procedures have failed, resulting in higher risks. Finally, unlike previous conservative treatment for acute myocardial infarction, presently many such patients are initially sent to the cardiac catheterization laboratory for aggressive interventions such as angioplasty or treatment with thrombolytic agents. As a result, increasing numbers of acutely ill and unstable patients subsequently reach the operating room for emergent surgical revascularization.

In recent years, there has been a dramatic growth of the angioplasty program at our institution, with approximately equal numbers of patients now having PTCA and operation annually. We have also previously demonstrated the increased risks associated with urgent operation following failed PTCA.[8] This group has a dramatic increase in requirements for intra-aortic balloon pump (IABP) support, lidocaine and inotropic infusions, greater blood loss and need for blood products, a three-fold increase in major complications and higher mortality. This trend is clearly seen in the present series, with an operative mortality following angioplasty of 4.8% (3/63) versus 0.9% (5/542) in the non-angioplasty group. Outcome for these patients may, therefore, already be determined according to preselection or to events occurring in the catheterization laboratory prior to operation. Awareness of these changes in the baseline characteristics of patients is essential if both physicians and patients are to have more realistic expectations regarding operation.[9]

There is no panacea in the realm of cardiovascular disease and therapeutic decisions are often difficult. Clearly, surgical revascularization and angioplasty are complementary procedures and the choice of invasive therapy should be individualized for any particular case. Because PTCA is a new procedure, however, there may be a tendency to overuse and a corresponding deficiency of meaningful data regarding its application.[10] When compared with surgical revascularization, PTCA is certainly more amenable to repeat procedures due to its less invasive nature, but re-stenosis following angioplasty implies return or exacerbation of symptoms or even sudden death during each interval prior to repeat dilatation. Younger patients have a considerable future life expectancy. As noted in the case of the elderly,[1] we feel strongly that these years are better spent active and asymptomatic, not punctuated by repeated hospital admissions. Extensive follow-up in our surgical patients previously,[9] and in the present series, has confirmed the effectiveness of aortocoronary bypass, with substantial return post-operatively to asymptomatic status. This salutary effect is particularly important in younger patients, who are usually able to resume vigorous physical activities and continue employment following operation. As surgeons, we concur with the concept that a single, durable, predictable procedure, namely aortocoronary bypass, is often the most prudent choice.[11]

Because control of risk factors and use of pharmacologic agents are unable to completely eliminate the relentless progression of atherosclerosis, all current forms of treatment for

TABLE 1: DEATHS

AGE/SEX	CAUSE	CATH < 24 HOURS	COMMENT
60 M	Cardiac arrest	No	Previous cardiac surgery, Acute MI
55 F	VSD/MI	Yes	Acute MI, pre-op IABP
60 M	Multi-system failure	Yes	PTCA, CHF
63 M	Multi-system failure	No	Uneventful procedure, Died 1 week post-op
45 F	Cardiomyopathy	Yes	PTCA, acute MI
53 M	Acute MI, cardiac arrest	Yes	CHF, acute MI, pre-op IABP
42 F	Acute MI	No	Acute MI
47 M	Cardiac arrest	Yes	PTCA, acute MI

ischemic heart disease, including surgical interventions, are at best only palliative. There continues to be an alarming incidence of re-operations for bypass grafting, due to both appearance of new lesions in native vessels and to late graft failure. Extensive studies have shown the susceptibility of saphenous vein grafts to atherosclerosis, with 50-60% of these grafts significantly infiltrated with atherosclerotic disease after 10-12 years.[12-13] Although most patients in the current study underwent revascularization using one or more saphenous veins, the search for a better graft continues. The use of internal mammary graft conduits in almost every instance currently, with a 95% 10-year patency rate and significant improvement in patient longevity,[5-6] is expected to further potentiate the lasting benefits of operation.

In light of our present experience, improvements in operative therapy for ischemic heart disease appear to have at least kept pace with increased demands. Continued development of new technologies and analysis of existing data will hopefully assist us in the decision making process and improve the overall care of our patients.

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"SUCCESSFUL PTCA:" CAMELOT OR BARNUM?

Norman H. Baker, MD
George J. Brahos, MD
Patrick J. Moore, MD
Peter M. Sanfelippo, MD
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Percutaneous transluminal coronary angioplasty (PTCA) is reviewed. Particular attention is given to the pathology, "success rate," morbidity, mortality and longterm results. It is apparent from this review that the longterm success of PTCA is in considerable doubt.

Introduction

Percutaneous transluminal coronary angioplasty (PTCA) has become one of the most common invasive procedures in the cardiovascular world. In 1984, approximately 85,000 procedures were reported. In 1985, over 106,000 were performed, and in 1986 there is a projected 50% or more increase.*

Percutaneous angioplasty had its beginning in 1964.[1] Marked impetus was given to the procedure by Gruentzig in 1977, with the addition of balloon dilating catheters.[2] Since Gruentzig's initial report, interest in this problem has advanced by leaps and bounds. It is timely to take a critical look at this procedure with respect to the pathology, "success rate," mortality, morbidity and long-term results.

Pathology

Originally, it was proposed that PTCA "remodeled the atheromatous material in the arterial wall by compressing it into a smaller volume."[3,4,5,6] Recent histopathologic studies have shown no evidence for remodeling of atherosclerotic material.[7,8] Post-mortem studies have shown dilatation of the stenosis due to separation of the plaque from the underlying tunica media and stretching and thinning of the media with frequent medial rupture. The integrity of the vessel may be maintained only by the adventitia. Splitting of the intima and aneurysm formation, rather than compression, are the mechanisms of increased luminal diameter resulting from transluminal angioplasty.[7]

"Successful PTCA"

After reviewing the pathology, it is difficult to understand the reported "success rate" of 90+% by many interventional cardiologists. Successful PTCA is defined as "a reduction of degrees of diameter narrowing by greater than 20%" by a committee report from the registry of the National Heart, Lung and

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Blood Institute.[10] It is also defined as a 40% or more improvement in luminal diameter of at least one coronary artery at the Mayo Clinic.[11] If one should report their "success" as defined by the committee of the National Heart, Lung and Blood Institute, decreasing a 90% stenosis to a 70% stenosis would be "a success." This "success" would leave a 70% stenosis, a severe physiologic obstruction.

Translesional pressure gradients are thought to be significant predictors of future re-stenosis by some and of little value by others.[12,13,15] With smaller catheters in use today, the pressure gradient should gain more favor as a means of predicting early results.

Thirty to 53% of patients with "successful PTCA's" have re-stenosis within six months.[8,9,15,16] The criteria for re-stenosis are as confusing as those for a "successful PTCA." Four definitions are suggested in the NHLBI study to accommodate different angiographic definitions already in use: 1) An increase of at least 30% from the immediate post-PTCA stenosis to the follow-up PTCA stenosis, 2) An immediate post-PTCA stenosis of less than 50% that increased to ≥ 70% at follow-up, 3) An increase in stenosis at follow-up to 10% below predicted stenosis or higher, 4) A loss of at least 50% of the gain achieved at PTCA.[8]

Inaccuracies in assessing the degree of stenosis are dependent upon the techniques of the observer. The normal visual reading of the angiogram has been compared with computer-assisted coronary angiographic analysis. This study has shown pre-PTCA stenosis read visually was overestimated when compared with computer readings. In the post-PTCA patient the opposite assessment occurred.[14] A number of patients have multiple "successful PTCA's."

A patient was recently seen by one of our surgeons for an acute iliofemoral artery occlusion. This occurred post-PTCA. The past history was interesting.

NOVEMBER, 1982 — Cardiac Catheterization.
Diagnosis: Mild aortic stenosis with coronary artery disease (70% stenosis LAD, 20% stenosis circumflex).

OCTOBER, 1983 — Cardiac Catheterization.
Diagnosis: 50% stenosis LAD, 85% stenosis circumflex, mild aortic stenosis.

NOVEMBER, 1983 — "Successful PTCA" circumflex coronary.

FEBRUARY, 1984 — Coronary angiogram.
Diagnosis: 75% stenosis LAD.

MARCH 2, 1984 — "Successful PTCA" LAD.

JUNE, 1984 — Coronary angiogram.
Diagnosis: Re-stenosis LAD
NEXT DAY — "Successful PTCA" LAD

AUGUST, 1984 — Coronary angiogram.
Diagnosis: Re-stenosis LAD
"Successful PTCA" LAD — Aortic valve gradient 50-60 mms of mercury.

FEBRUARY, 1985 — Coronary angiogram.
Diagnosis: Aortic stenosis 70 mm gradient.

OCTOBER 5, 1986 — Coronary angiogram.
Diagnosis: Aortic stenosis 80 mm gradient. Circumflex coronary 50-60% stenosis.

OCTOBER 24, 1986 — "Successful PTCA" Aortic Valve.
Diagnosis: "100 mm" gradient reduced to 55 mm of mercury.

OCTOBER 25, 1986 — Endarterectomy of thrombosed left iliac artery.

If the PTCA site is patent one year after angioplasty, re-stenosis rarely occurs."[20] "Late re-stenosis seems to be exceptionally rare."[21] Typically, these statements are made without valid statistical support. Hirzel and co-workers followed the first 50 patients reported by Gruentzig, et al, for five years. Primary success occurred in 32 patients (64%). Nine of these 32 patients were excluded from follow-up because three requested surgery when angina re-occurred, five were lost to follow-up and one died of other causes. Of the remaining 23 patients, eight (16%) had no radiologic evidence of significant re-stenosis or progression of disease at the end of five years. They concluded — "this treatment seems to have a long-lasting effect and may represent a definite alternative to coronary artery bypass surgery."[21] This is a profound statement for a procedure with a documented five year "success rate" of less than 50%.

One wonders what the acceptance would be for a surgical procedure with a failure rate of 30-50% within six months. It is apparent that the term "successful PTCA" could have been coined by the late P.T. Barnum or a modern contemporary.

Morbidity and Mortality

The overall complication rate reported by the NHLBI registry in "successful PTCAs" was 21%. Serious complications, defined as a need for emergency bypass surgery, death or myocardial infarction, occurred in 9%.[8,9]

Emergency coronary artery bypass graft surgery is reported in 3.7 to 21% of patients undergoing PTCA.[17,19] Indications for emergency CABG include prolonged chest pain, increased coronary artery obstruction, cardiogenic shock, coronary artery dissection and intractable ventricular fibrillation or cardiac arrest. Morbidity and mortality is increased in this subset of patients. The incidence of acute myocardial infarction is 43% and operative mortality 4.4 to 11.3%. This is three to four times the mortality of an elective CABG.[18,19]

We feel that PTCA mortality statistics should reflect these figures. A 30-day morbidity and mortality figure would seem reasonable as is the case in a surgically reported series.

Left main coronary artery stenosis has been reported following cannulation for direct cardioplegia in patients with aortic valve replacement. The etiology has been thought due to local trauma with resulting stenosis. This has recently been suggested in seven cases reported by Killen, et al, following PTCA.[17]

Prospective Randomized Trials

Ten years have passed since Gruentzig's initial report on the technique of transluminal coronary angioplasty. In this decade, there have been no reports comparing PTCA with medical therapy or surgery. Seven years following the initial report of successful CABG, two randomized trials were well underway and a third major study had begun.[22,23,24]

Currently the NHLBI is designing a multi-center randomized trial to evaluate the relative efficacy of PTCA versus CABG. It is hoped that this will include comparison of medical therapy in single vessel, as well as multi-vessel disease.

Discussion

Initially, the use of PTCA was restricted to patients with single-vessel coronary disease. Recently, it has expanded to patients with multi-vessel disease, and, in a few hands, it has become the treatment of choice in all patients with coronary artery stenosis, reserving surgery for the complications of PTCA.

Dr. John Kirklin has questioned the propriety of PTCA in single-vessel disease.[25] "One wonders if that can be justified in the face of the essentially zero mortality of placing an internal mammary artery bypass graft to this vessel, and ten year patency rate for the internal mammary artery of about 96%. The ten year survival in such situations is about 93%. With a single hospitalization, a single very safe operation, and with near freedom of concern about their disease for at least ten years, perhaps internal mammary artery grafting should be the initial treatment for patients with high grade proximal anterior descending coronary artery disease, rather than PTCA."

It is commonly inferred that cost savings are substantial in the PTCA group of patients versus CABG. Jang and Associates report a $7,149 savings per patient.[26] Unfortunately, they failed to add the cost of stand-by for surgeons, operating room and anesthesia. They also did not include the cost of repeat PTCA, repeat cardiac catheterization and emergency or subsequent coronary artery bypass grafting. A recent Mayo Clinic report compared PTCA and CABG expenses in patients with single vessel disease.[27] One year after the procedure, the outlay in the PTCA group was only 15% lower than the patients with CABG. A longer follow-up will undoubtedly narrow this cost difference significantly.

Eventually, the results of PTCA will have to be compared with the results of surgical and medical therapy. Randomized trials, that are in the design stage, will be of significant help in this evaluation. We hope this will provide the primary physician a firm statistical basis for decisions that are so important for the long-term well being of his patients.

Summary

A review of the pathology, "success rate," morbidity, mortality and long-term results following PTCA are presented. The reported "success rate" and high incidence of re-stenosis are confusing. It seems clear that the longterm durability of PTCA is in considerable doubt. We all await longterm prospective randomized trials of PTCA with medical therapy and CABG to determine its role in the treatment of patients with coronary artery disease.

"Camelot — It Is Not."

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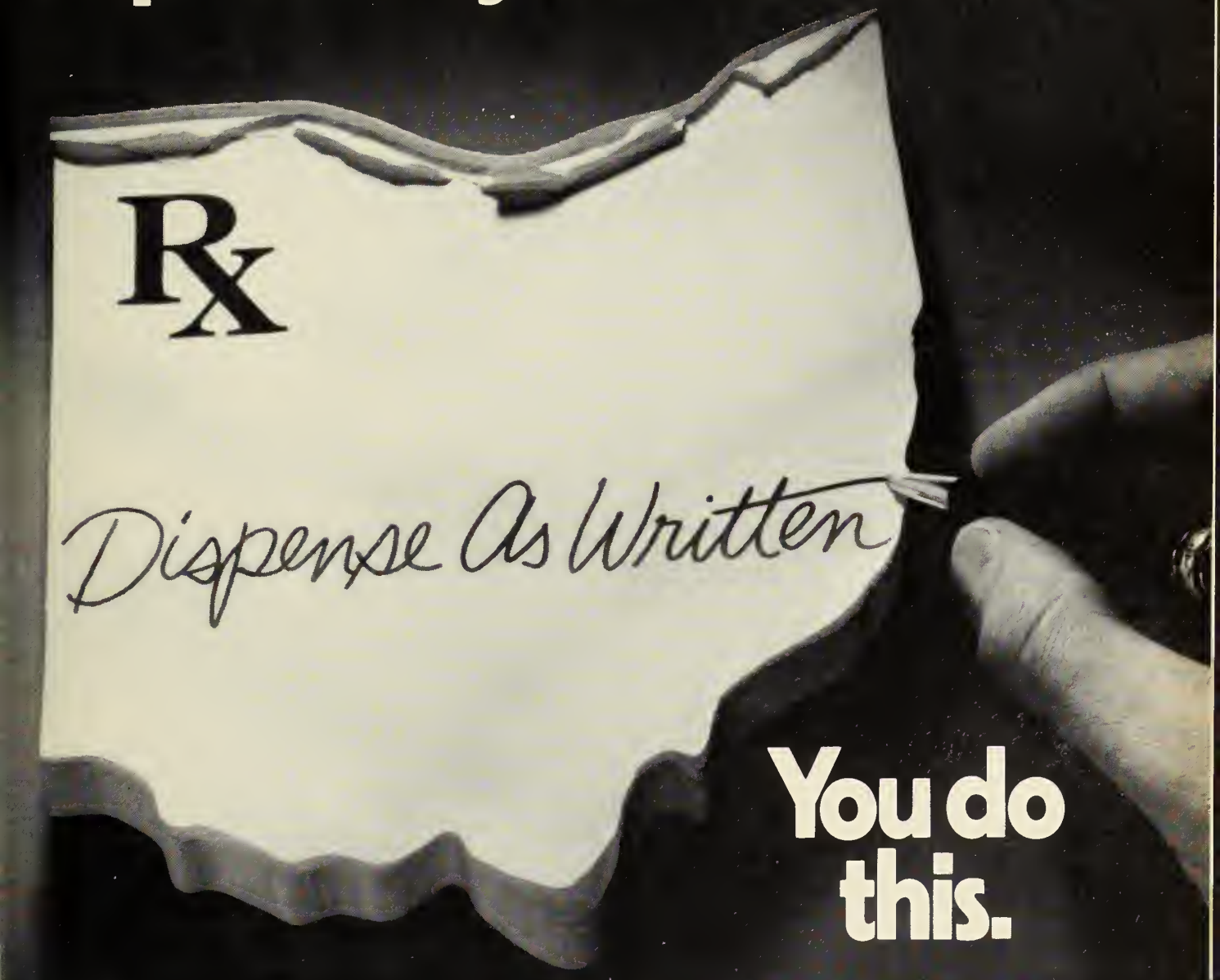
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THEOPHILE ANDJUS, MD, Lima; Bursa Tip Fakultesi Istanbul Universities, Bursa, Turkey, 1948; age 66; died July 2, 1987; member OSMA and AMA.

ROBERT BUSSE, MD, Toledo; St. Louis University School of Medicine, St. Louis, MO, 1955; age 56; died July 3, 1987; member OSMA and AMA.

EDWARD BUFORD, JR., MD, Batavia; Meharry Medical College, Nashville, TN, 1944; age 67; died July 20, 1987; member OSMA and AMA.

CLARENCE COTTERMAN, MD, Hebron; Ohio State University College of Medicine, 1962; age 60; died July 17, 1987; member OSMA.

JUAN GHERSI, MD, Canton; Universidad Nacional de Cordoba, Facultad de Ciencias, 1949; age 75; died August 7, 1987; member OSMA.

GEORGE P. GRECOS, MD, Toledo; Faculty of Medicine University of Thessalonika, Thessalonika, Greece, 1964; age 50; died July 26, 1987; member OSMA.

VITALIJ HOLONKO, MD, Youngstown; Medizinische Fakultaet der Ludwig Maximiliams Universitaet, Muenchen Bayern, Germany, 1951; age 73; died July 14, 1987; member OSMA and AMA.

KENNETH KURTZ, MD, Venice, FL; Eclectic Medical College, Cincinnati, 1928; age 88; died July 25, 1987; member OSMA and AMA.

ELLIS W. LIST, SR., MD, Bristolville; University of Louisville School of Medicine, Louisville, KY, 1931; age 83; died July 20, 1987; member OSMA and AMA.

JOHN C. MARKLEY, MD, Northrup; University of Southern California School of Medicine, Los Angeles, CA, 1947; age 65; died August 1, 1987; member OSMA and AMA.

ROBERT McCAFFERTY, MD, Sheffield Lake; St. Louis University School of Medicine, St. Louis, MO, 1933; age 80; died July 26, 1987; member OSMA and AMA.

WILLIAM MEWBORN, MD, Toledo; Ohio State University College of Medicine, 1934; age 80; died July 14, 1987; member OSMA and AMA.

VICTOR M. SHAMPTON, MD, Dayton; Ohio State University College of Medicine, 1953; age 61; died July 24, 1987; member OSMA.

SUKHDEV R. SINGLA, MD, Dayton; Guru Nanak Medical College, Guru Nanak University, Amritsar Punjab, India, 1958; age 54; died July 22, 1987; member OSMA and AMA.

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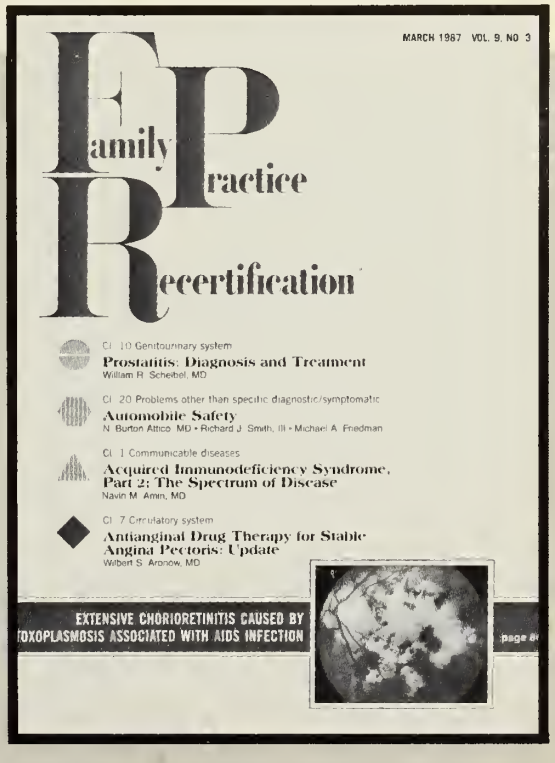
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continued on page 733

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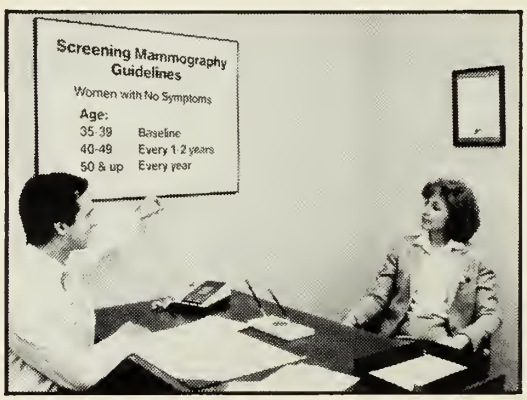
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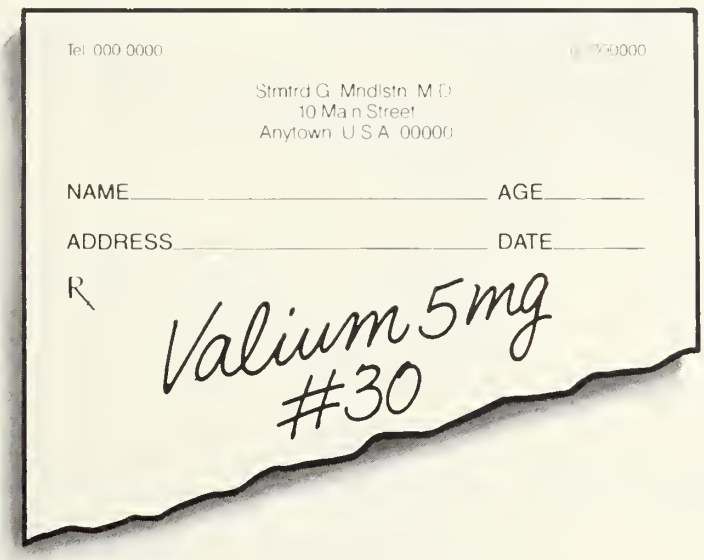
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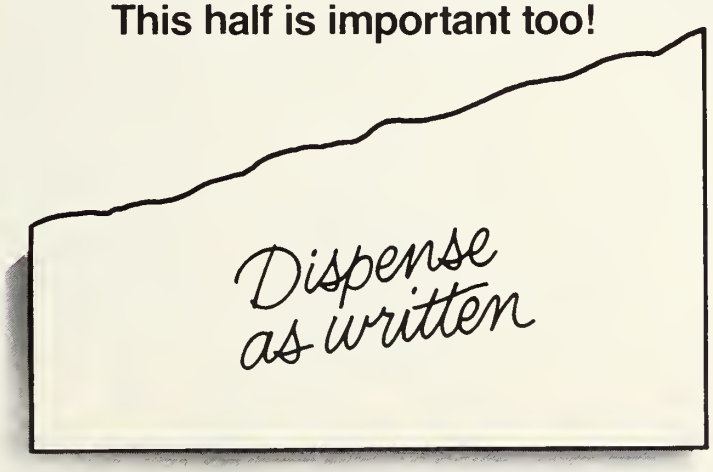
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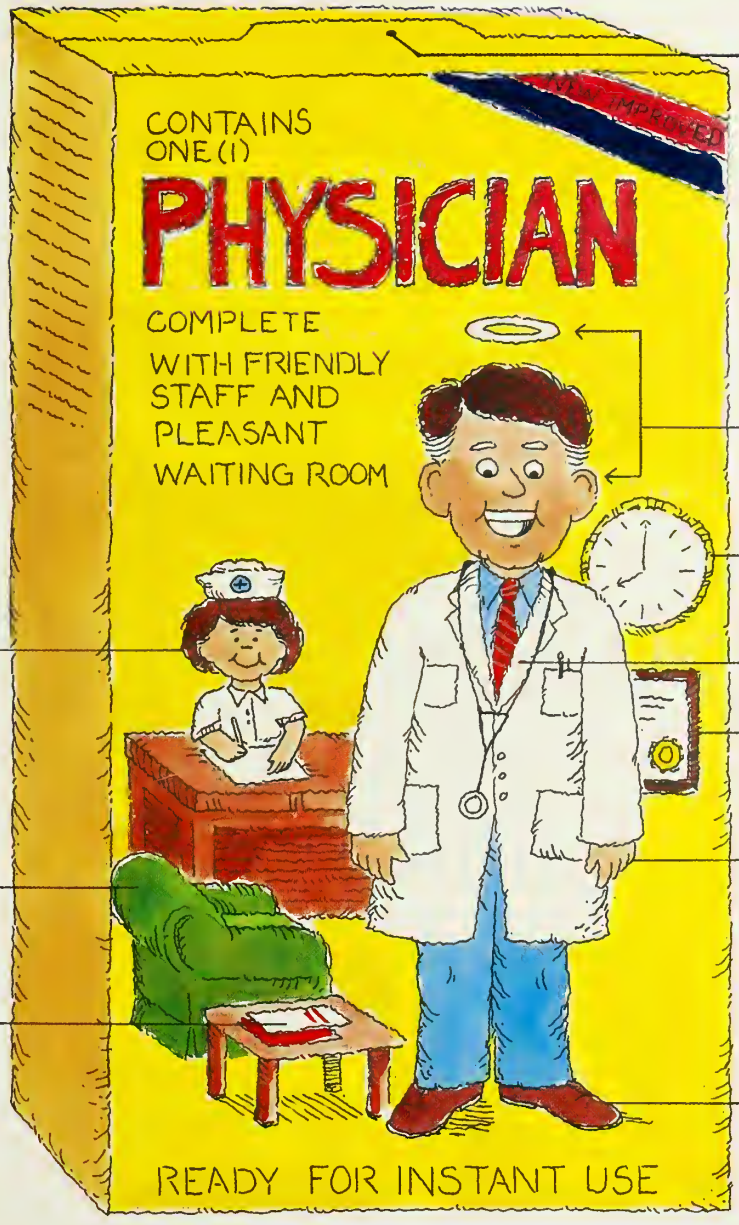
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JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

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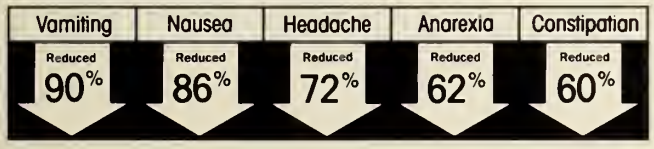
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Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy*: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
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Published monthly under the direction of The Council for and by members of OHIO Medicine, 600 South High Street, Columbus, Ohio 43215, a scientific society, non-profit organization, with a definite membership for scientific and educational purposes.

1987 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: OHIO Medicine, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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FROM THE EDITOR



Packaging Your Practice ...

No one ever told you, as you grappled with the long hours, complex decisions and awesome responsibilities of your medical training, that only *half* the battle of being a doctor is becoming one. For a doctor, no matter how well-trained he or she is, is hard-pressed to claim the title if there are no diseases to diagnose . . . no illnesses to cure . . . no wounds to heal. In short, a doctor is not a doctor without patients, and there is nothing on your medical diploma that guarantees you a patient . . . let alone a waiting-room full of them . . . just because you put in your time and got the training. But, then, nothing says you have to resort to a used-car dealer's bag of tricks, either. There is a happy medium out there — a level at which you can actively build and maintain a comfortable patient-load without having to appear on the front of a cereal box.

This issue of OHIO Medicine gives you tips and hints on how to package your practice — based on information that will be contained in a new physician-marketing handbook, currently being prepared by the OSMA's Department of Communications and Physician Marketing. This issue will carry the first three chapters of that handbook with subsequent chapters serialized in a special marketing column. You'll want to check future issues, as well as this one, for your "sneak preview."

Also in this issue . . .

. . . a story on the newly-created Young Physician Section, chaired by Victoria Ruff, MD, a Columbus intensive-care physician. Associate Editor Deborah Athy has not only provided a thorough look at this increasingly-active section, but has rounded it out with some nice profiles of young physicians as well.

. . . a report from the OSMA Task Force on Capitation Reimbursement Systems.

. . . a discussion of "Melanomas and Nevi," presented by members of the dermatological society for our Specialty Update section.

. . . an inside look at the war in Afghanistan, provided by a Lancaster physician who has been there to help train the rebel troops in medical care.

. . . a celebration of two progressive surgical techniques marking medical milestones this year. You'll find this story in our Medi-scene section.

Next month, we'll bring you updates and news from the OSMA Clinical and Scientific section, held this past September in Columbus — and separated for the first time this year from the OSMA's Annual Meeting. Watch for it!

Karen S. Edwards

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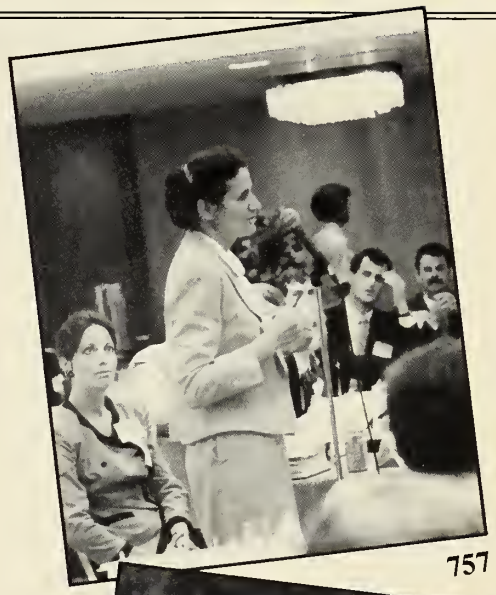
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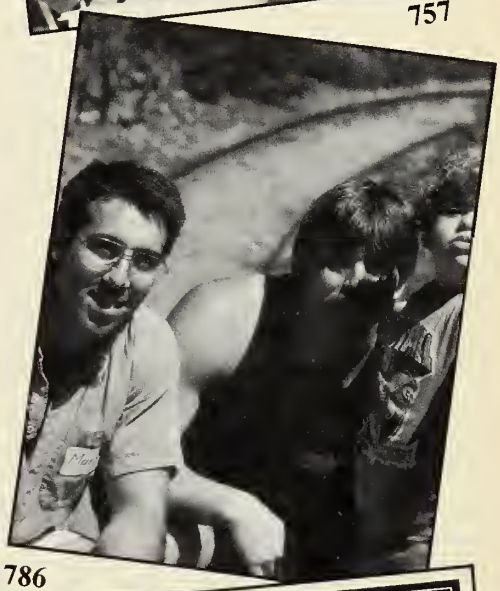
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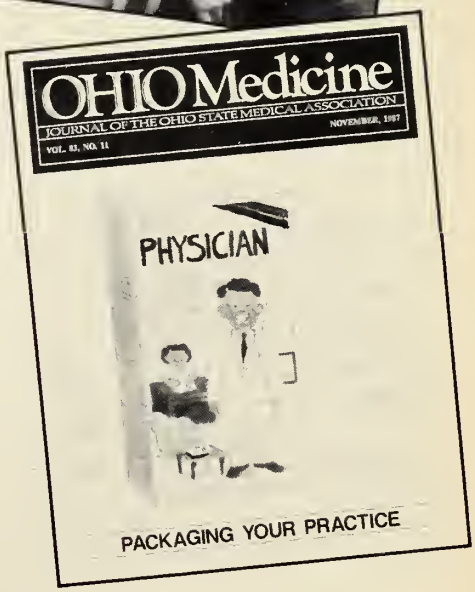
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Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: *Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component and/or other sulfonamide-derived drugs.*

Warnings: ***Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.*** *If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.*

Precautions: *The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin[ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.*

Adverse Reactions: *Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.*

Supplied: ***'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.***

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Freedom of Choice . . . A Question for Today

By D. Ross Irons, MD

For some time now I, and I think many members of the medical profession, have been acutely aware of the fact third-party payors are becoming more and more involved in the physician-patient relationship. Needless to say, this interference is uninvited. At no time has this action received the blessing of the majority of physicians and it is certainly without the understanding or knowledge of patients.

The most recent evidence of this situation is the Health Care Financing Administration's attempt to blame a proposed Part B Medicare premium increase on the cost of physicians' services. This charge is totally without merit. After all, our fees to Medicare patients have been frozen for years.

One of the reasons for the reported increase in the physicians' services component of the Medicare program can be traced to the federal government's successful efforts, over the past few years, to move Medicare patients' services from the more expensive hospital setting to the physician's office. It seems obvious to me, and you would think it would seem obvious to HCFA, that by taking this action the program would experience a decrease in the cost of hospital services and an increase in physician costs. Instead however, HCFA tries to place the blame on physicians.

In order to set the record straight, the OSMA issued a strongly-worded news release which received widespread attention around the state. After all, if we aren't conversant with the facts and ever ready to respond, who will?

As onerous as the recent Medicare premium hike episode was, it is far from the only example of the third-party's ever-increasing intrusion into our domain. Think for a moment of HCFA's new OBRA Medicare requirements for non-participating physicians.

These requirements, which went into effect October 1, 1987, do two things:

1. They require that non-participating physicians give patients written notice when elective surgery procedures will cost $500 or more and assignment will not be accepted.
2. They require that non-participating physicians make refunds to patients, under certain circumstances, when unassigned services are determined to be "medically unnecessary" after reimbursement has been made by Medicare.

I think this is pure harassment and yet another attempt to sanction the non-participating physician and deliver a blow to fee-for-service medicine — the very same system which over the years has proven itself again and again as far as excellence and quality are concerned.

A third example of the continuing effort to destroy the physician-patient relationship is the increased activity of insurance carriers in conjunction with large industrial corporations to ration health care on the patient's side and to increase discounting on the physician's side.

Today's practicing physician is faced with an ever-increasing array of so-called "cost containment" theories, promulgated by an endless number of health-care reimbursement entities, to the extent that no physician's office can possibly be expected to know when, where, and how to obtain necessary approvals.

In my opinion, these time-consuming activities accomplish very little in terms of cost savings, and, in many cases, actually contribute to cost. All too often, these health-care review agencies or carrier cost containment departments which dictate second

continued on page 803

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To the Editor:

I read with great interest your recent articles focusing on the medical malpractice issue. The articles provided much useful information on measures to be taken after being named in a malpractice suit. However, they failed to address structural remedies to the malpractice crisis. There are several possible measures that would greatly alleviate the problem.

1. A cap on awards for pain and suffering of $250,000. Multi-million dollar verdicts often arise from pain and suffering awards; few Americans have a lifetime earnings potential that exceeds one million dollars. A cap on pain and suffering awards would help keep awards within the limits of insurance policies and protect physicians' personal assets.
2. The use of structured settlements. Paying malpractice awards over an extended period can substantially reduce the amount of money needed up front for a given claim with resultant considerable savings.
3. Abolition of the contingency system. Presently, plaintiffs have a total absence of disincentives to initiate a lawsuit. A victory in a malpractice suit offers the opportunity to win up to millions of dollars. A defeat does not cost the plaintiff a dime. Millions of Americans spend billions of dollars on lottery tickets when the chance of a given ticket winning is almost infinitesimal. Malpractice lawsuits don't require the expense of ticket purchases, and given the vagaries of jury verdicts even questionable claims may have a better chance of winning than a lottery ticket.
4. Limit attorneys' fees if the contingency system cannot be abolished. Patients receive far less than half of the malpractice premium dollar. The workman's compensation system in several states provides an example of how attorneys fees can be successfully curbed.

Ronald G. Kaczmarek, M.D.
Gaithersburg, MD



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†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.



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Brief Summary
Professional Use Information

CARDIZEM®
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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutogenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%).

Rx

Cardizem® (diltiazem HCl)

☐ 60 mg ☐ 90 mg

☐ 120 mg

Sig: tid

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing

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AIDS: Let's Get It Out of the Closet

By Stanley Fox, MD

Editor's note: *This article is reprinted from* **Liberty News and Views,** *a Cleveland publication*

We all agree AIDS is an infectious disease. The culprit is the AIDS virus, also called the HIV (Human Immunodeficiency Virus) or HTLV-III/LAV, which eventually results in loss of immunity and the fatal symptoms of AIDS (Acquired Immune Deficiency). A person infected with the HIV may have no symptoms for years and still be able to pass this deadly disease on to others.

The next question is why are physicians not recording the results of positive HIV tests on hospital charts, thereby endangering other physicians, nurses and health-care workers? Why are they withholding information from insurance companies, lying on death certificates, and deceiving spouses and other sexual contacts whose lives may be saved by knowing they are in danger of being exposed to the AIDS virus? There is no question but that we must find solutions to the problems of strict confidentiality in order to protect infected patients from job, insurance and housing discrimination, and homosexual baiting. However, we must never lose sight of the fact that we are dealing with an infectious and lethal disease. Although there have only been 304 cases of AIDS reported in Ohio as of January 1987, it is estimated that 40,000 people in Ohio are already infected with the AIDS virus (HIV) and approximately 1.5 to 3.5 million people throughout the country are also infected. It is estimated that by the turn of the century, over 100 million people will be infected worldwide. Over 60 percent (possibly 100 percent) of these HIV positive patients will develop the fatal symptoms of AIDS in the next five to 10 years or longer.

It is alarming that politicians and physicians in charge of AIDS programs are so influenced by certain high risk groups that are predominantly infected and by the ACLU, that they are attempting to relegate this deadly disease to the status of a mere handicap. They are so preoccupied with the desire to protect the anonymity and rights of those infected that they are oblivious to the fact that we are dealing with one of the most lethal infectious diseases that has threatened the human race.

Unlike other infectious diseases, it is not required that people infected with HIV be reported to the local health department or public health service until they develop terminal AIDS symptoms. By that time the patient has probably been spreading the disease for years. The public health service has no idea of how many people are actually infected. There is no attempt to notify intimate contacts, such as spouses, that they may be in danger. The attitude is that as long as there is no cure for this disease, why inform people that they are infected — thus allowing them to keep passing it on to the next person. They have even put obstacles in the way of family physicians finding out if their patient is infected. Unlike other laboratory tests, their physician must have written permission in order to obtain the HIV blood test, and to make matters worse, the patient may request that the laboratory withhold the information from the doctor who ordered the test.

Because the Communicable Disease Center in Atlanta, Georgia, has no idea how many people are actually infected, they have come up with the brainstorm of secretly ordering HIV tests on blood already drawn on hospitalized patients which was used for other testing. But, in their infinite wisdom, they have decided to remove the labels from the specimens so that they won't know which patients are infected. They

continued on next page

It is a shame that the majority of physicians, who definitely know better, have sat back and remained silent and allowed AIDS to become a political football ...

merely want to know how many people are infected, but have decided not to determine who is infected. They would thus be eliminating the possibility of notifying patients that they are infected with the AIDS virus, which might explain why they are in the hospital in the first place, as well as protecting health workers and family members from the spread of this disease. Withholding this information may not only be immoral, but may actually be criminal.

Although we know that casual contact poses little or no risk, whenever a doctor, dentist, or health-care worker who handles blood or other body fluids becomes infected with the AIDS virus (HIV), we are informed by so-called experts that no health-care worker in the United States has ever contracted AIDS from a patient. They also hint that these workers must secretly be in high risk groups such as homosexuals or IV drug users. Yet they probably would not raise as many questions if a health worker contracted serum hepatitis, which is also a virus which is transmitted by blood or other body fluids.

The California Medical Association, which represents a state that ranks second only to New York in the number of AIDS cases, is now advocating the relaxing of the rules of confidentiality and strict patient consent laws in order to begin approaching the AIDS virus with the proper infectious disease procedures. They recommend: deleting the legal requirement for consent to HIV testing that is stricter than the usual informed consent for medical care; releasing positive HIV test results to the local public health department and the patient's physician; allowing physicians the right, after testing and counseling a patient, to notify an endangered third party of their exposure to a person with a positive HIV test; and allowing blood banks and health departments to share information for the purpose of locating and informing people of any transmittable blood-borne disease. These resolutions are proposed in order to provide health-care providers methods to deal with AIDS as they would any other infectious disease.

It is a shame that the majority of physicians who definitely know better have sat back and remained silent and allowed AIDS to become a political football just because in this county, the disease initially involved predominantly homosexuals or bisexuals (approximately 85 percent of cases).

AIDS is a virus that shows no sexual discrimination. In Africa, the distribution of AIDS cases is 50-50 between males and females. Because, in some areas of the United States, over 50 percent of the prostitutes are infected, especially in areas where IV drug use is rampant, it probably will not be long before we see a more rapid increase in heterosexual to heterosexual spread. We must use other infectious and sexually-contracted diseases as models. Syphilis, for instance, has been responsible for millions of deaths. Text books of dermatology and syphilology in the early 1900's suggested that doctors counsel their patients never to have sexual intercourse again. There were no good treatment or cures. Things tried were: fever or heat treatment; malaria; heavy metals such as mercury or bismuth; and arsenic. Not until the 1940's did penicillin become available. What we did learn was that routine testing, notification of spouses and other endangered third parties and counseling of high-risk groups helped to stem the spread of this disease. The apparatus for this is already in place and should be utilized by the public health service and local health departments to help slow the spread of the AIDS virus until adequate treatment or vaccine is developed.

This is one time I can side with President Reagan and William Bennett, the Secretary of Education, who have advocated routine testing for HIV, using the same rules that we follow for other infectious or sexually-contracted diseases. Testing should be so routine that there is no stigma involved in ordering the HIV test. More testing centers should be established where tests can be obtained free or at a reasonable fee, along with counseling. It costs the state $4 to $5 for this test, yet most private laboratories charge over $40. This would also help to protect our blood supply. Authorities seem to be blind to the fact that many people who want to know if they are infected run down to their local blood bank to donate blood.

Although the HIV test has been attacked by the ACLU as dangerous because of false positives, it is really very accurate when combined with the Western

Blot confirmatory test. Remember, these are the very tests we use to safeguard our blood supply. Testing is an irreplaceable tool in infectious and sexually-transmitted disease control but should not be subsidized by cutting funds for AIDS research and education which are equally important aspects in this fight.

We must not let our infectious disease control be determined by Elizabeth Taylor, the ACLU, gay activists, right wing gay bashers, misinformed congressmen, or AIDS researchers with no field experience in sexually-transmitted disease control. **OSMA**

Stanley Lowell Fox, MD, is the past VD consultant for the City of Cleveland; Chairman, Infectious Disease Committee of the Ohio Dermatological Society; member, Cleveland AIDS Task Force; and member of the Ohio State Medical Association AIDS Task Force.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine *or the Ohio State Medical Association.*

Correction

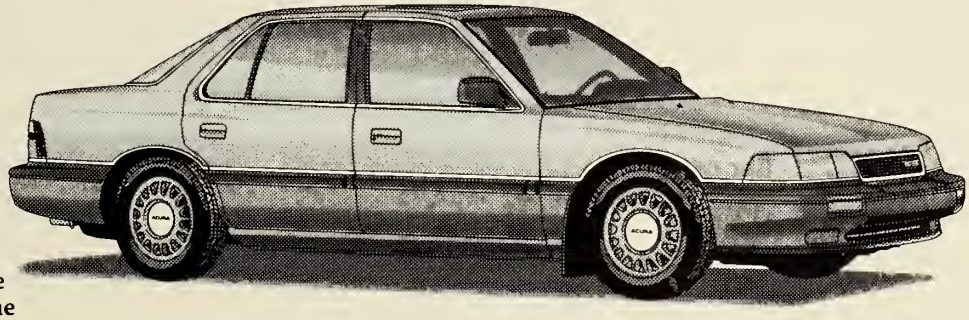
Thomas R. Leech, MD was identified incorrectly last month as practicing plastic surgery in Gallipolis. He practices in Lima. Dr. Thomas Morgan, former Chairman of the Membership Committee, practices in Gallipolis. *OHIO MEDICINE* regrets the error.



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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Assume your patients have heart disease

Presume heart disease unless you can prove otherwise — that's the word from the Congress on Sports Medicine and Science, which believes that physicians should assume all adults seeking medical examinations in strenuous sports probably have coronary heart disease.

Wake Forest University physician Henry S. Miller, MD says the high incidence of coronary artery disease and hypertension in the U.S. demands that today's doctors be suspicious of all common medical problems associated with the patient's age, especially those related to sudden death.

"Most sudden deaths in athletes have occurred in individuals who have played the specific sport for 5-10 years or have been running 4-5 years," he says. "It is also important to realize that cardiovascular abnormalities associated with congenital disease may worsen with age and that the intensity with which a person exercises usually increases with age."

Dr. Miller says simple, practical methods can identify most cardiovascular problems. For example, he says, a good current medical history that includes information about childhood and adolescent problems and a physical examination that looks specifically for problems such as blood pressure abnormalities, heart murmurs and variations in cardiac rhythm are sufficient to reveal the vast majority of cardiovascular problems.

More specific studies will detect carotid and aortic abnormalities that might present life-threatening problems in younger athletes and symptomatic coronary artery disease that occurs in older athletes, Dr. Miller says.



Retire to Ohio

Most people planning their retirement look to the Sunbelt as a place to enjoy their later years, but according to a recently-published book by Peter A. Dickinson, *Retirement Edens: Outside the Sun Belt,* Ohio has four places which are worth consideration — Oxford, Waverly, Chillicothe and Columbus.

Dickinson took into consideration a city's climate, cost of living, housing, medical facilities, recreation and culture and special services for senior citizens before assigning it a "good" or an "excellent" rating. All four Ohio cities were entered in the book as "good."

Hear no evil

Rumor has it that part of the reason seasoned rock-n-roller Pete Townsend gave up strumming on stage was because the long years of roaring amplified music had finally taken a toll on his ears.

But lest rock-n-roll should get a bad name . . . it's not just rowdy rockers who are prone to music-induced hearing difficulties. Bernard Fleshler of the Buffalo Philharmonic Orchestra reportedly suffers from tinnitus caused by many years in the orchestra pit.

Fleshler — following in the footsteps of Benjamin Franklin, another famous inventor with the same initials — came up with an idea to soften the musical blow: the Acoustishield. This foam rubber cushion adheres to the back of a chair and curves around the sides of the head to absorb the sometimes-earsplitting music.

The lightweight shield can lessen the intensity of the percussion section a few feet away to a level heard from 20 feet. Or, as a fellow musician explains, the Acoustishield can mellow the sound of a loud trumpet to that of a loud flute or clarinet.

One can only ponder how long it will take 'til the Acoustishield has its heyday on MTV.

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COLLEAGUES IN THE NEWS

Bernard B. Bacevich, MD, a Cincinnati orthopaedic surgeon, was recently honored by the Fairfield Board of Education for providing scoliosis screening of Fairfield schoolchildren over the past 10 years.

James Baird, MD, a Columbus gynecologist, has been named vice president for medical affairs for U.S. Health Corp.

Thomas F. Barrett, MD, a Poland radiologist, was recently installed as clinical staff president of the Western Reserve Care System for a two-year term.

Wilma F. Bergfeld, MD, a Cleveland dermatologist, was installed as president at the annual meeting of the Cleveland Academy of Medicine.

Thomas J. Comerford, MD, Bay Village, has been elected to the board of trustees of the American Heart Association, Northeast Ohio Affiliate, Inc.

Henry G. Cramblett, MD, Upper Arlington, was reappointed to the State Medical Board for a five-year term ending March 18, 1992.

Robert B. Daroff, MD, a Cleveland neurologist, has been appointed editor-in-chief of the American Academy of Neurology's scientific journal, *Neurology.*

Charles Donley, MD, a Zanesville internist, was elected to the board of directors of Good Samaritan Medical Center.

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OHIO MEDI-SCENE

Medical milestones . . . AIDS in Ohio — an update . . . restoring the sound of music . . . CWRU's new book on cancer . . . research in Ohio . . .

Medical milestones . . . happy anniversary to two surgical techniques

Coronary bypass surgery and total hip replacement surgery are both celebrating anniversaries this month, and a medical journal would be remiss if it didn't devote at least some space to these two surgical techniques which continue to enhance the quality of life for millions of Americans today.

Coronary bypass surgery

The bypass operation is 20 years old, and is performed on about 225,000 Americans with heart disease every year. According to Rene Favaloro, MD, the Argentinian surgeon who pioneered the technique at the Cleveland Clinic in 1967, not much has changed, technically, with the operation itself.

"The techniques used then had been simplified and standardized," he says, so there was no real room for any further improvement — it worked (and still works) whether the bypass was a single, double or triple one. "However, changes and improvements have been made in the operation as it relates to other events," Dr. Favaloro continues, naming, specifically, the invention of the heart-lung machine and the protection of the heart through cardioplegia. "Improvements in





Above: Total hip replacement surgery is performed in a completely sterile environment. Below: Coronary bypass surgery.

OHIO MEDI-SCENE

Medical milestones . . . *continued*

the magnification of lenses and improvements in anesthesia have also made a difference," he claims, explaining that such improvements have made it possible to perform the operation on high-risk patients, such as those with hypertension or on elderly patients.

Then or now, however, Dr. Favaloro is convinced of one thing — coronary bypass surgery not only enhances the quality of life but also substantially increases the number of life-years following an operation.

"Patients now live as long as 10 years after an operation," says Dr. Favaloro. In fact, the most glowing testament of this extended quality of life is Eugene Pottenger, a 73-year-old Illinois resident who was Dr. Favaloro's first patient. Pottenger is still alive today — some 20 years after his bypass operation.

That's not to say, however, that the coronary bypass is for every heart patient, Dr. Favaloro hastens to add.

"The doctor has to carefully elect those patients who are appropriate and weigh the operation against other techniques which are available." Such methods as balloon angioplasty and the use of the drug TPA (tissue plasminogen activator), a new development in coronary care, need to be considered when deciding the treatment of choice, he continues. One thing that should *not* be considered, however, is the Coronary Artery Surgery Study (CASS), conducted several years ago, he says. This study implied that, while bypass surgery may ease the pain of some patients with angina, it isn't going to lengthen their lives.

"CASS has many pitfalls," says Dr. Favaloro. "For one thing, the study was conducted on an extremely low-risk population which makes it unfair."

The press, however, leaped on the study's outcome without recognizing the disservice they were creating for patients with serious heart problems, he continues. Hearing that bypass surgery won't increase the length of their lives, these patients are apt to refuse the very operation that will keep them alive.

"And if an operation is indicated," adds Dr. Favaloro, "there *is* a chance for greater longevity."

Currently, about six to 10 bypass surgeries are being done each day — both at the Cleveland Clinic, and at the Buenos Aires hospital in which Dr. Favaloro presently practices — and despite the other methods available for treating coronary disease, he doesn't see that the number of bypass operations will decrease significantly in the next 10 years.

"Patients now live as long as 10 years after an operation . . ."

"In 20 to 30 years, yes, it could be possible that the number of bypasses will decrease as new techniques and methods are found. Laser angioplasty, for example, may very well reduce the number of bypass operations that are needed."

Until that technique is further developed, however, or some other, newer method found, Dr. Favaloro will continue doing the bypass surgeries he pioneered 20 years ago this month — and which remain one of the most viable and life-enhancing tools in medicine's arsenal today.

Total hip replacement arthroscopy

Unlike the coronary bypass operation, total hip replacement surgery has made considerable advancements since a French surgeon, by the name of Dr. Judet, first experimented with joint replacements by inserting one-half of a total hip to the femoral shaft, as a treatment for arthritis. Unfortunately, the fit that was made by Dr. Judet was a "press fit," one not fixed in place by either screws or cement, so the half-hip would often work its way loose in just one or two years.

But the limited life-span of the half-hip was not its only drawback, says David K. Halley, MD, a Columbus orthopedic surgeon who is one of only 20 Fellows in the U.S., and the only Fellow in Ohio to study under Sir John Charnley, the British surgeon who pioneered total hip replacement arthroplasty.

"Charnley got his idea for joint replacement by listening to a man tell him that he couldn't tolerate eating breakfast with his wife, a

previous half-hip replacement patient, because she 'squeaked.' "

According to Dr. Halley, Charnley surmised that the squeaking was due to high friction, which caused the joint to loosen and, eventually, become painful. But if the socket could be lined with plastic — Teflon, for example — and both it and the metal femoral head affixed to the bone with methylmethacrylate (a dental cement), could the problem be corrected?

He first tested his theory in the laboratory, carefully checking Teflon for its ability to tolerate wear. It checked out very well, but once inside the body, the Teflon sockets devised by Charnley wore out in a matter of three years — an improvement, to be sure, over Judet's squeaky, two-year prototype — but there was definitely room for further improvement.

In fact, after having to revise each of the 300 hip replacements he had initially performed, Charnley was almost ready to abandon the procedure — until, one day, a salesman came into his office with some high-density polyethylene plastic. It had promise, but the salesman was unable to tell Charnley what it's rate of friction was so Charnley ordered the man from his office.

"Unbeknown to Charnley, the salesman took this material down to Charnley's research laboratory and asked the technician there to put it on the wear machine," relates Dr. Halley. "It was found that it took two weeks to wear down the same amount of high-density polyethylene it took to wear down in one day on Teflon."

In November of 1962, then — with the correct materials at hand — John Charnley performed his first current-model total hip replacement arthroplasty. Of the 1,200 hip replacements performed each year at England's Centre for Hip Surgery, 60 of the original patients are still living, and their hips are functioning well, reports Dr. Halley.

In fact, in a review of 106 hip replacements done by Dr. Charnley and followed for 10 years, his early techniques performed very well, with a loosening rate of only 2 percent.

In America, however, a design other than Charnley's was used, and while the replacements were, at first, quite gratifying, their 10-year follow-up showed a high loosening rate. Since that time, of course, great strides have been made both in surgical technique and design, says Dr. Halley.

"At this time, it is suggested that the loosening rate in American total hip replacements will be less than one percent at 10 years. This is a real credit to American surgeons," he says.

Other improvements that have been made in this area include the invention of special sterile air rooms, and "space suits" worn by joint replacement surgeons — both of which have been designed to reduce the high infection rate that typically accompanies this type of operation.

"Also, there are developments in using bone ingrowth hip replacements, which are basically used for younger patients," says Dr. Halley. The idea, here, he continues, is that the bone will grow into the implant, and perhaps give a more lasting result than bone cement.

As far as the future of joint replacement surgery goes, Dr. Halley describes it as "bright."

"We have an older population and as more and more people become older, there is more arthritis," he points out. Total hip replacement surgery will be able to help many of these people.

"Also, hips are now being designed to have replaceable sockets, so if the plastic does wear out, it would not be unrealistic for us to 'open the hip' and insert a new plastic liner without disturbing the socket replacement or femoral component," Dr. Halley adds.

A 'well-done' total hip replacement should last 20 to 25 years before a revision (is) needed"

"John Charnley anticipated that a 'well-done' total hip replacement — in a properly selected patient — should last 20 to 25 years before a revision might be needed," Dr. Halley says.

And who knows? By the time the *50th* anniversary of total hip replacement arthroscopy rolls around — that wear-rate might be even better. — *Karen S. Edwards*

AIDS in Ohio — an update

According to statistics released this past August, the number of reported AIDS cases in Ohio has risen to 439, making the state the 15th in the country in the number of cases, behind such states as New York (10,905), California (8,836) and Florida (2,553). Of the Ohio figure, 267 cases (61 percent of those reported) have ended in death.

The typical Ohio AIDS patient appears to be white, male, between the ages of 30 and 39, and a member of the homosexual risk group, although the statistics reveal that at least five new cases have been acquired through heterosexual contact.

Nationwide, 38,160 AIDS cases have been reported through August, with 21,915 (or 57 percent) of those being fatal.

OHIO MEDI-SCENE

The sound of music . . . restored

Whether it's the classic marionette beats of the "Nutcracker Suite," or the soulful saxophone of jazz artist Art Pepper: if the reception is less than optimum, even the finest music pales.

Two Cincinnati otolaryngologists wanted to right the record, so to speak, and give individuals with hearing difficulties a chance to get into the musical groove, without experiencing a lot of static.

The solution? Robert E. Whited, MD, and Thomas J. Kereiakes, MD, donated a state-of-the-art wireless FM transmitting system to Cincinnati Music Hall. Its magic? This pocket-sized device resembles a small portable radio and produces an amplified, interference-free rendition of the performance. Because the devices are portable, the individuals with hearing difficulties may sit wherever they like — and they can carry the music aids as easily as a pair of opera glasses.

Nothing has been done in our public institutions, whether they be churches, courthouses, or music halls, to maximize the pleasure of the hearing impaired, explains Dr. Whited. He admits that it's taken awhile for technology to catch up with the needs of the patients. But now "so much in new technology can be done to enhance the quality of life, especially of public life, for the hearing impaired."

Drs. Whited and Kereiakes became attuned to the idea of music/performance hearing devices while studying medicine in Boston, one of several other U.S. cities having success with these kinds of hearing devices.



For those with mild to moderately severe hearing loss, the music aid "restores their ability to enjoy musical performances on par with someone with normal hearing," says Dr. Whited — especially valuable in an aging population, he adds.

At the ballet or opera, where there's usually an attentive audience, invariably there's a certain amount of "white noise" — coughing, rustling, shifting of seats, etc. The music aid amplifies the pure tone of the music — producing a stereo-like sound — while blocking out this background music, he explains.

Because the traditional hearing aid amplifies both the music and the background noise, the portable radio-like device is far superior for a symphony or music performance, Dr. Whited says. In fact, even those with normal hearing would probably find the music aids to be unusually refreshing.

The system had its debut July 2 for the opening of "Madame Butterfly" by the Cincinnati Opera. The response has been amazing, he says, with many patrons expressing their appreciation. All other performances by the Cincinnati Symphony Orchestra and Cincinnati Ballet will also offer the enhanced hearing service.

"Doctors get so much bad press anymore. It seems that when doctors help the community with time or talent, people never hear about it," Dr. Whited says. But the hearing system is just "an extension of the longstanding physician tradition of charitable donations," he points out.

Perhaps this tradition will resonate in cities all over the country. — *Deborah Athy*

Pulling out a plum: Case Western's new comprehensive cancer book

Perhaps the next thing you should pull out of your medical bookshelves should be a plum — that is, a recently-published primary cancer manual dubbed *The Plum Book* for its deep purple cover.

More than 60 physicians, including some of the nation's leading cancer experts, collaborated on *Primary Care of Cancer: Recommendations for Screening, Diagnosis and Management,* a 212-page manual explicating the 28 most common types of cancer.

Funded by a grant from the Cuyahoga County Unit of the American Cancer Society, the 1987 book was distributed to 8,000 primary care physicians, interns, residents and medical students in northeastern Ohio.

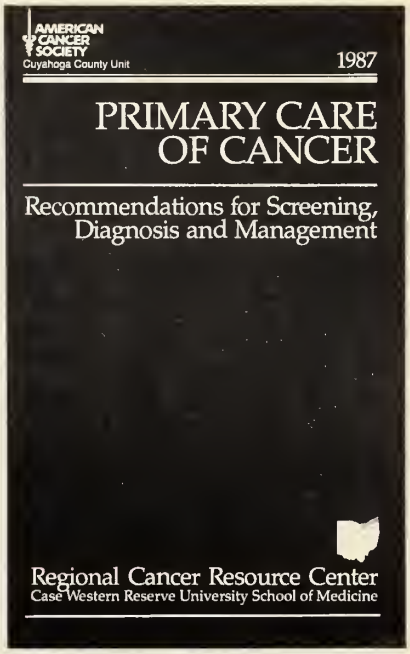
"The National Cancer Institute has set a goal of a 50% reduction in cancer mortality," points out Case Western Reserve University Dean Richard E. Behrman, in the foreword of the book. ". . . This manual is intended to provide a concise, practical guide to what the primary care practitioner can do in reducing cancer mortality."

Each chapter, written and reviewed by physician experts, includes a description of the cancer, staging systems, epidemiology and risk factors, etiology, prevention, screening, symptoms and signs, diagnostic tests, treatment, prognosis, and post-treatment follow-up.

"Perhaps most important is that it *(the Plum Book)* promotes prevention and detection," says CWRU Director of Media Relations Robert Daniels. "The wealth of information it contains is clear, concise, easy to read, and readily available."

Look for a review of *Primary Care of Cancer* in a future issue of *OHIO Medicine.*

For additional information, write Regional Cancer Resource Center, Office of Community Health, Case Western Reserve University, School of Medicine, 2119 Abington Road, Cleveland, Ohio 44106, or call 216/368-3660. — *Deborah Athy*



Case Western Reserve University's new "Primary Care of Cancer" promotes prevention and detection.

Research in Ohio

Editor's note: *The following summaries indicate the type of research currently being conducted in this state. It is, by no means, a comprehensive list, but it does show the impressive breadth of medical and scientific topics which are under investigation.* **OHIO Medicine** *welcomes contributions on this subject, and additional columns will be repeated as reports are received and assembled.*

Electromagnetic artificial heart

Michael Koroly, MD, Cuyahoga Falls, and two members of the University of Akron faculty have designed and completed work on a prototype electromagnetic artificial heart that pumps in the laboratory setting. The heart, weighing 18 ounces and about the size of a human fist, is made of titanium and polyurethane and requires no external apparatus. It is fully implantable. To recharge the internal battery, a recharger pack is attached to the person while asleep. In addition, a back-up battery is expected to be implanted that would temporarily control the pump in situations where the conventional recharging schedule is interrupted.

Surfectant and infant respiratory distress

Surfectant, a soap-like substance taken from the lungs of calves, is being used by researchers in Dayton to help premature infants breathe. Premature infants often lack enough surfectant in their own lungs to keep their breathing passages open, creating infant respiratory distress. The drug tests of calf surfectant are part of the process to seek FDA approval for its use. Results, so far, are promising. As of mid-July, 23 infants, all weighing less than three pounds and who have been treated with the drug since March, have been taken off respirator treatment earlier than normal.

Leu-endorphin and schizophrenia

Western Reserve Care System physicians, headed by A. James Giannini, MD, are studying a possible connection between body levels of a leu-endorphin substance, a potentially harmful substance that may result when the body breaks down its own morphine, and the diagnosis of schizophrenia and schizoaffective disorders (Bergmann's syndrome).

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Research in Ohio . . . *continued*

For 12 months, urine samples of schizophrenia and schizoaffective patients will be analyzed for the leu-endorphin.

Reversing memory loss

A new drug designed to reverse memory loss in Alzheimer's patients is under study at the Alzheimer Center of University Hospitals of Cleveland.

THA, short for tetrahydroaminoacridine, works by stimulating the production of a chemical crucial to memory and found lacking in Alzheimer's patients. The drug received widespread attention last November when a California study published in the *New England Journal of Medicine* reported markedly improved memory and function in 16 of 17 Alzheimer's patients who took THA.

Study participants will take THA daily by capsule, and will be seen by a physician weekly for the study's first seven weeks, then every other week for 14 weeks. The two-hour examinations will typically include blood tests, electrocardiograms and psychological testing to measure the degree of functioning memory.

Prostate cancer and ultrasound

The Ohio State University hospitals in Columbus is one of eight medical centers studying the use of ultrasound in the detection of prostate cancer. The study, called the National Prostate Cancer Detection Project, is an attempt to determine if ultrasound has greater accuracy in the diagnosis of prostate cancer as compared to the currently accepted testing methods. Researchers at the eight medical centers plan to evaluate approximately 5,000 men between the ages of 55 and 70 who show no symptoms of prostate cancer. They will be evaluated annually over a five-year period. If ultrasound testing is proven to be more efficient in detecting prostate cancer, researchers would urge that its usage be adopted at hospitals nationwide. — *Karen S. Edwards*

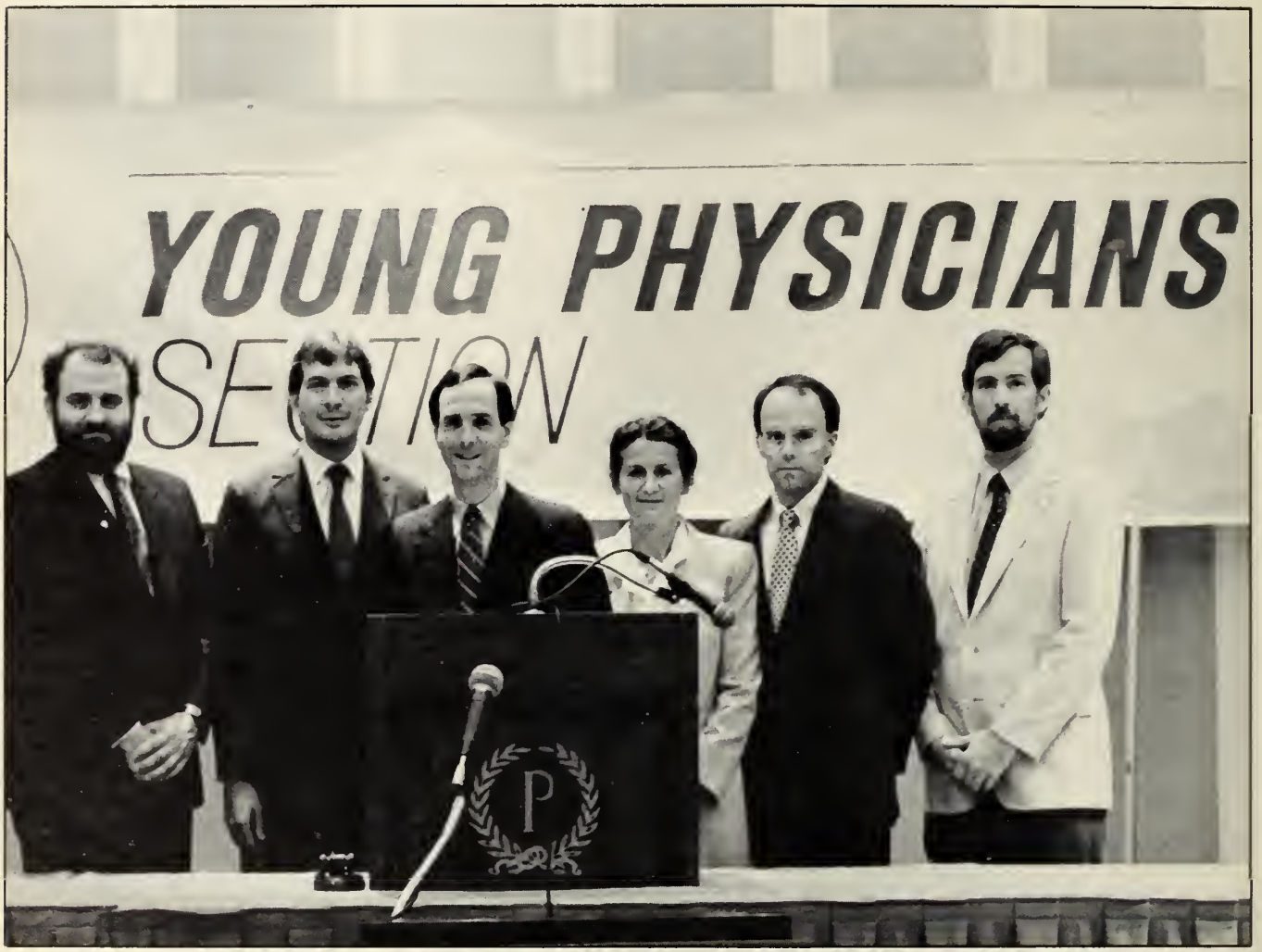
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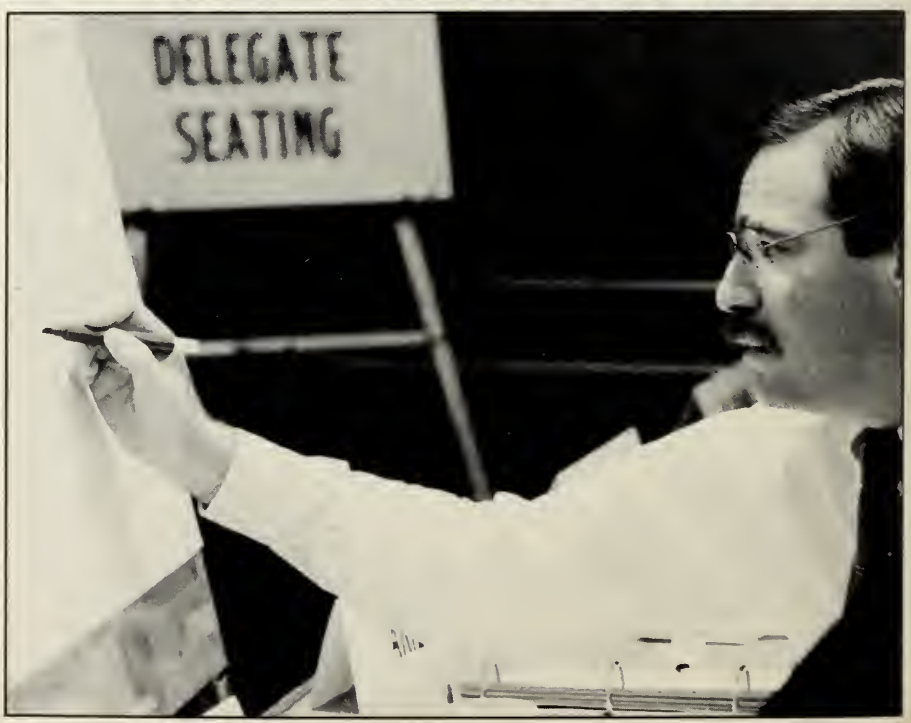
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Above: The Governing Council of the AMA-YPS are (left to right): Clayton Griffin, New Jersey; George McGee, Mississippi, President-Elect; Michael Cullins, Massachusetts, President; Victoria Ruff, Ohio; Lee Newcomer, Oklahoma; Robert Bowman, Texas.



Right: A delegation from Arkansas was among those participating in the Young Physician Section at AMA headquarters.

Young Physicians: A Hidden Resource

By Deborah Athy

So you finished medical school: said goodbye to the all-night sessions, stacks of medical books, empty wallets . . . And now that you've finally completed your residency — learned the ropes, made the rounds, answered the late-night calls — you're on easy street. Right?

Not so fast. According to young physicians already plying their trade out in the field, suddenly there's a whole new agenda of concerns to contend with: how to pay off those looming student loans; what kind of practice to join, or should you dare start your own practice; how to learn the "business" of medicine; how to balance a hectic practice and still see your family on a regular basis; how to beat the heat of the malpractice cauldron . . . and so on.

According to the AMA, young physicians are "those individuals who are under age 40 or within the first five years of professional employment, excluding physicians in residency or fellowship training." While 53% of all practicing physicians fall into this category, less than 30% of young physicians have taken the plunge into the ranks and files of organized medicine.

The question is "why?" The AMA established a two-year ad hoc Committee on Young Physicians in 1984 to come up with some answers to explain the low young physician membership.

Several years of research, surveys and analyses later, the committee presented a report to the AMA House of Delegates with the following recommendations: 1.) "That the AMA establish an Assembly of Young Physicians to be comprised of one delegate and one alternate delegate from each state . . . and 2.) That the AMA strongly encourage and assist each state in establishing a state-level Assembly of Young Physicians as a means of strengthening the direct and meaningful participation of young physicians throughout the Federation."

Following the AMA recommendation, the OSMA Council voted in favor of establishing a Young Physician Committee in March 1987. Chaired by Victoria Ruff, MD, an intensive-care physician from Columbus, the committee is composed of two young physicians from each OSMA district.

This past September, the newly-created OSMA Young Physician Committee met to brainstorm ideas on the concerns and challenges facing young physicians as well as to establish the committee's goals, says Dr. Ruff, who is also a recently-elected member-at-large of the Governing Council of the AMA-Young Physician Section.

The committee examined, for example, some of the concerns recently culled from AMA and OSMA young physician surveys, including: increased indebtedness following medical school; the exorbitant cost of establishing a practice; more salaried employment; incomes not keeping pace with inflation; a higher priority on free time; and a lack of identity with organized medicine.

Regarding this last concern, the appointing of two "resource" people from each OSMA district is an excellent way to get interest in organized medicine rolling at the grass roots level, Dr. Ruff points out. The resource people will act as information links, channeling information from national and state levels to the local level, and vice versa — fulfilling one of the primary objectives of the young physician group: keeping young physicians informed of legislative issues, political scoops and OSMA/AMA benefits and services — whether they're practicing in Urbana, Youngstown or Portsmouth.

Debbie Messick, MD: A Few Good Reasons to Join

What's in it for me? That's what most physicians want to know before they start paying out dues money for organized medical groups, says Debbie Messick, MD, a Columbus general surgeon in practice since July.

In just a few weeks, Dr. Messick has found that organized medicine can make a young physician more visible, an especially important consideration when a physician is just starting out and trying to build a steady referral base, she says.

Dr. Messick's first favorable introduction to organized medicine was while attending Ohio State University, where she received her MD degree in 1981. It was there that she joined the American Medical Women Association (AMWA), an organization of which she's currently secretary-treasurer.

"I can tell you how much it (AMWA) has helped me," says Dr. Messick, who completed her surgical residency at OSU in 1986. "About half my referrals come from contacts I have made in this group, which is really saying a lot." After all, the name of the game in many ways is to build a demand for your services, which isn't possible unless people know your services are available.

In some ways you have to *market* yourself — a term she says she hesitates to use . . . but somehow you have to get the word out that you're working — you have to network, make introductions, join hospital committees, etc. Organized medicine can be a means to that end, she adds.

After completing a specialty residency in colorectal surgery at Grant Medical Center in June, Dr. Messick worked with the AMA physician placement services and perused in-town and out-of-state work possibilities. She wasn't interested in private practice because of a lack of time, money and flexibility, and deep down she wanted to stay in Columbus and go the general surgery route. She's currently with a small group of well-established surgeons, and says she's pleased with this arrangement.

One of only a few women surgeons in the state, Dr. Messick says there are a number of advantages to being a woman physician. For one thing, many women prefer to go to a woman physician, she points out.

While she considers herself a "joiner," she says she understands the reluctance of some young physicians to get involved in organized medicine. Establishing a practice, making time for family obligations — "these things are overwhelming in themselves," she says. But perhaps busy young physicians don't realize that enhancing one's visibility and recognition will pay off in the long run.

"Some physicians are afraid to get involved. They think they're going to make one phone call and then they're going to have this huge time commitment. They want to be involved, but they don't want to be overwhelmed," she says.

That's why it's important for medical groups to communicate effectively with potential members: how much time is involved, what is expected of them, how to get involved, and

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In this way, organized medicine hopes to provide young physicians with a *reason* — rather than an *obligation* — to join the organization, Dr. Ruff explains.

"In the past there was a feeling that you *should* belong to the AMA or the OSMA . . . but one of our goals is to have young physicians *want* to belong. We want them to feel that there is more to organized medicine than just paying dues."

The Young Physician Committee has also penciled in such goals as addressing issues specific to young physicians; increasing involvement; increasing the number of leadership positions; increasing membership; involving young physicians in policymaking decisions; and instilling a sense of responsibility to maintain the integrity of the profession.

While a strong membership base breeds clout in the political den, the impetus behind the young physician group is not merely to increase young physician membership, but to mainstream young physicians into the framework of organized medicine. "It's essential to have young physicians in leadership positions, so that their needs and perspectives are made known at all levels of organized medicine," she points out.

Over in Chicago, the national young physician movement is also picking up momentum. Suzanne Meyering, Director of the AMA Young Physicians Services, reports that recent months have seen greater numbers of young physicians joining organized medicine. In fact, at the 1987 AMA Annual Meeting, nearly every state sent a delegate and alternate delegate to the Young Physician Section (YPS).

"The main reasons for young physicians not joining is that they don't perceive the value of organized medicine . . . but the

benefits are obvious," she says, citing representation at the national and state level, accessibility to policymaking, and opportunity to safeguard quality of care as examples.

She also points out that young physicians are underrepresented in the makeup of organized medicine, not only in membership but in leadership roles. Thus, the young physician groups enable greater numbers of new physicians to quickly gain visibility.

Ohio already had a head start in this area, she continues. The seeds were already in place for a trend toward greater involvement by the under-40 physician population, so in some way Ohio can serve as a model for other states, she says.

But because each state's needs are a little different, each young physician group must tailor its structure and goals a little differently.

Ohio, for example, may be more responsive than other states as far as membership (according to a 1986 Young Physician survey, nearly 75% of the respondents reported they are OSMA members), but the national figures sagged significantly, with just 50% reporting AMA membership.

The survey also showed that while young physicians have some unique concerns, they share many of the same problems as other physicians. In answer to the question, "What do you feel should be the top priority of organized medicine today?" the top three answers were 1.) resolving the professional liability situation; 2.) reducing government regulation of medicine; and 3.) advocating high quality care.

Young physicians report that the services they would find most beneficial would include financial and tax planning seminars; practice management services; and assistance in filing insurance and government claims. In addition, at

The Right Choices: Pediatrician Glenn Trippe, MD

Upon finishing his residency at Akron's Children's Hospital in 1979, Glenn Trippe, MD, of Port Clinton, had some choices to make.

He could, as he had originally planned, pursue an interest in medical research, or, in order to repay a government scholarship, he could opt to devote time in a public health facility. Choosing the road more agreeable with his post-graduate financial status, he spent two years in South Carolina as a rural health initiative physician for the U.S. public health service.

A 1976 graduate of the Medical College of Ohio, Dr. Trippe then set his sights on a solo pediatrics practice in Port Clinton — a decision which ushered in its share of hurdles. "It takes time and money to set up a practice. Then, of course, there are the difficulties of being accepted in a small town. Setting up a solo practice is an extremely tenuous proposition."

Today's increased competition and greater number of physicians create even more obstacles for young physicians, he continues. That's why he understands the prevalence of young physicians taking harbor in larger groups, the *safety in numbers* philosophy. Looking back he admits, "I don't know if I could start solo again. . . ."

For any young physician interested in pursuing a solo career, business know-how is an important skill to acquire. "Anymore, you have to be a pretty shrewd businessman to successfully run an office," he points out. The complex maze of business applications, insurance payment programs and various red tape is intimidating to those unfamiliar with the "business" of medicine.

"Fear of failure is considerable," Dr. Trippe affirms, so many physicians shy away from diving into a solo office endeavor and trying to stay afloat. Business finesse could be taught in residency programs or med students could intern in physician offices while in school, he suggests. One way to get one's feet wet in business orientation is by enrolling in the AMA practice management courses, he adds.

Dr. Trippe learned the business of running a medical office perhaps the hardest way of all — by trial and error. He picked up pointers along the way, from his experience in the public health service and in his private practice, until gradually his office operations became more sophisticated and more computerized. "You have to learn to run a very tight ship," he says — or you'll sink.

While Dr. Trippe acknowledges that a solo practice is difficult to get off the ground, he doesn't believe it's a lost art. "Medicine has been brainwashed into thinking that private practitioners are going to die out and be replaced by the alphabet soup of medicine. I don't believe it," he says. "I don't believe my patients want a McDonald's style medicine. They want a personal physician who knows them, recognizes them and has their best needs at heart."

In fact, Dr. Trippe believes the public will finally tip the scales in favor of the private practitioner. "It's only a matter of time until the general public gets tired of stepping up to the window for a styrofoam version of medicine."

One way to avoid being swept up by the alphabet soup of medicine is by getting involved in organized medicine, he suggests. "There's enough opportunity if

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Above: Ohio physician Victoria Ruff, a member of the Governing Council of the AMA-YPS, makes a point on the floor of the House.

Left: Members of the newly-formed Young Physician Section of the American Medical Association.

the second AMA-YPS meeting in June 1987, members requested information on such things as legislative activities, official AMA policies, specifics of the MAAC program, and the benefits provided to AMA members.

Organized medicine is gearing up to address these requests — first, by offering practice management workshops; and second, by working to improve its communications with member physicians, Dr. Ruff explains.

"The AMA is still the best mechanism by which young physicians can make their issues and perspectives known."

"The AMA is still the best mechanism by which young physicians can make their issues and perspectives known," she says. "But our representation at the national level can only be successful if there's strong involvement at the state and local level as well." One way Dr. Ruff hopes to generate involvement and supply information is by having committee members speak at medical staff section and hospital committee meetings around the state.

In the past, there's been a common perception that young physicians were not being listened to — whether because their numbers were too minimal or their concerns weren't being voiced at the appropriate forums. That's unfortunate, Dr. Ruff says, because young physicians are a source of knowledge waiting to be tapped. Perhaps somewhere in this group lie the answers to some of the medical questions presently being asked, she points out.

YOUNG PHYSICIANS COMMITTEE

Secretary of Committee: David C. Torrens

NAME	ADDRESS	TELEPHONE
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Robert Waluzak	East Ohio Regional Hospital Martins Ferry, Ohio 43935	(not available)
Daniel L. Whitmer	3351 Stonebridge Road Dayton, Ohio 45419-1237	(not available)

Robert Bowman, MD, Young Physician Representative to the AMA House of Delegates, recently pointed out that a membership of "new and active members will tie together the old and the new and bring new ideas and perspectives to the AMA."

At the national AMA meeting, some 80-90 young physicians from around the nation provided a "fresh approach" to the business of organized medicine. Dr. Ruff agrees. "We want to channel those ideas and goals and really make a difference." **OSMA**

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Report of the Task Force on Capitation Systems of Reimbursement

By Herman I. Abromowitz, MD, Chairman; Z. Charles Fixler, MD; Frederick Karaffa, MD; Alan H. Klein, MD; K. William Kitzmiller, MD; George Leicht, MD; William T. Paul, MD

In 1986, OSMA President John E. Albers, MD, appointed a task force to study, evaluate and make recommendations concerning capitated systems of physician reimbursement. Ohio (second only to California) has in excess of 80 operational health insurance plans, many of which are considering or offering some type of capitated payment system to physicians. OSMA members are feeling acute pressures to participate in various alternative delivery systems, many of which are designed as capitated systems rather than traditional fee-for-service.

Over several months, the task force studied and received testimony from experts directly involved in capitated insurance plans. Generally, the task force found that the issues surrounding capitation as a form of physician reimbursement are highly complex and controversial.

The task force focused its efforts on the perceived advantages and disadvantages for patients and for physicians participating in a capitated insurance plan. The impact that this participation may have on the physician-patient relationship was reviewed with emphasis on economics, ethics, contractual commitment, legal implications and quality of care.

While there are many interpretations of the term capitation, for the purpose of this report, *capitation is defined as a prospective payment system that reimburses physicians for comprehensive medical services provided for a contractually agreed upon amount, for a set period of time, usually monthly.*

Capitated systems of reimbursement require that *"access"* to the health care delivery system be *"managed"* by a primary care physician. *"Managed access" is the method by which primary care physicians control capitated patients' access to the health care system.* The terms most commonly used to describe this physician-managed access concept are "gatekeeper and case manager." Generally, gatekeeper physicians assume financial risk only at the primary care level, where often, case managers assume total financial risk for both primary and referral care. The primary difference between the two terms, which is the byproduct of "managed access," is the amount of direct risk assumed by the primary care physician. What constitutes a primary care physician is defined differently by the various health plans. For example, some plans include certain specialists not traditionally considered primary care physicians. It is imperative that any physician contemplating joining a capitated plan

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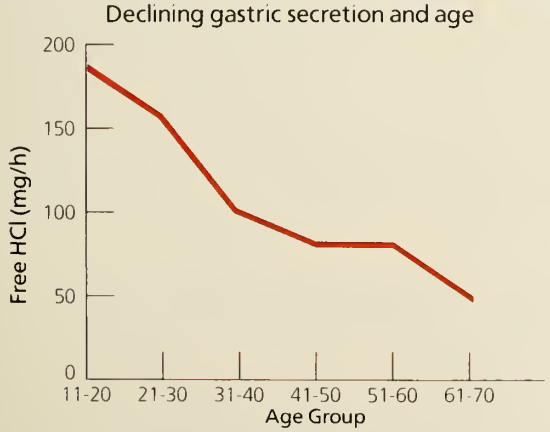
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Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

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References:
1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 62-69, 1984.

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understand the concept of "managed access" and fully understand his or her responsibilities under such a contractual relationship. A fundamental difference between "capitated" and "fee-for-service" insurance plans is the method by which capitated patients gain access to the health care delivery system.

As a result of its deliberations, the task force identified advantages and disadvantages for patients and physicians participating in a capitated reimbursement system.

Perceived Advantages and Disadvantages for Physicians in a Capitated Reimbursement System

Advantages

- Maintain market share with potential to increase patient volume.
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- Eliminates the need for patient billing and claim form submission.
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- Provides the environment for medicine to respond to health care cost concerns of business and industry.

Disadvantages

- Physicians must accept patients assigned to them by the plan.
- Transfers the financial risk of health care costs from the patient to the physician.
- Difficult to control patient utilization, with potential to increase administrative costs.
- Each member physician at risk for the financial success of the plan.
- Potential for adverse selection of patient.
- Potential ethical dilemma exists if financial risk dictates amount of patient care delivered.
- Disruption of existing physician referral patterns.

The task force strongly felt that as patient advocates, physicians should also consider the perceived positive and negative effects capitated systems of reimbursement may have on their patients. Therefore, the committee identified the following perceived advantages and disadvantages for patients in a capitated reimbursement system.

Perceived Advantages and Disadvantages for Patients in a Capitated Reimbursement System

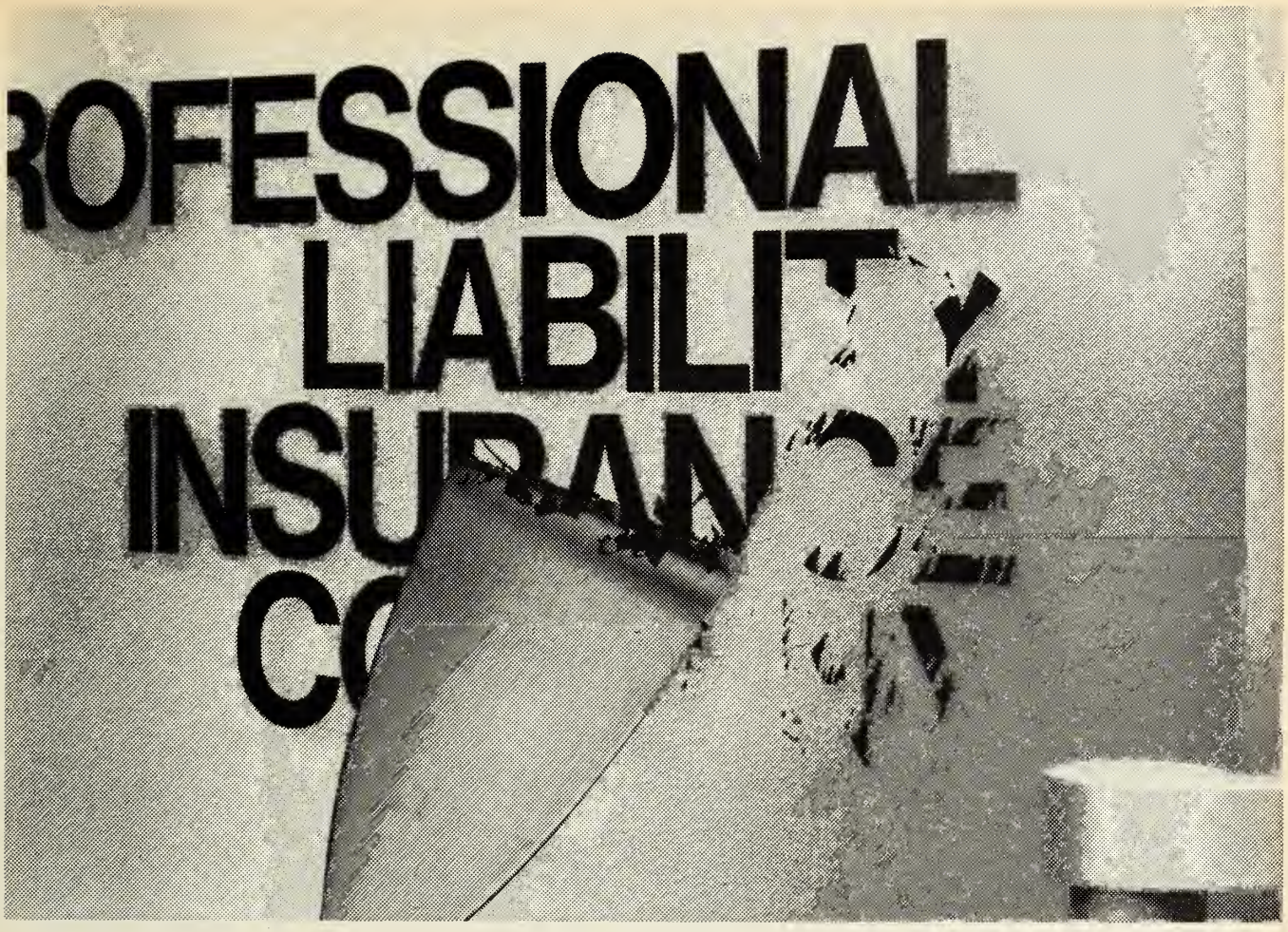
Advantages

- Permits predictable costs for comprehensive levels of care.
- Perceived unlimited utilization of covered health care services.
- Lower cost premium rates.
- Emphasis placed on preventive care.

Disadvantages

- Patient denied freedom of choice of physician and facility.
- Fear of physician disincentive to see or treat patients presents a potential incentive to withhold treatment in order to

continued on page 798



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By The Department of Communications and Physician Marketing

Introduction

It used to be that when a new physician went into practice, all he or she had to do was rent office space, hire a receptionist, put out a shingle and wait for the telephone to ring. Waiting rooms in even the most remote parts of the state were bulging at the seams with patients willing to wait hours to see a doctor, and the physician's greatest problem was that there weren't enough hours in a day.

We don't have to tell you that in most parts of the state and nation, all of that has changed. Today's sophisticated patients are much less patient — if you can't see them at a time and place that is convenient for them, they'll simply go to the yellow pages and call someone else. Similarly, if they are unhappy with the way you treat them or with the care they receive, most will not hesitate to seek another opinion — or another physician.

The increasing number of physicians and other health-care workers in today's marketplace, along with a more knowledgeable and demanding public have made health care a big business in this country today — and, more and more, it is becoming a "buyer's" rather than a "seller's" market. The competition is just too great, and the loyalties are spread too thin.

So exactly how does one compete in today's overcrowded marketplace? How can one assure himself or herself a healthy patient load and practice? While the problems may be relatively new, many of the techniques are as old as the Hippocratic Oath.

For the new physician just starting out in practice, this means a much greater effort must be made in drawing patients into his or her practice. Even the veteran physician can no longer sit back and depend on simple reputation and word-of-mouth to draw new patients — or even to keep his or her current patient population intact.

Most experts agree that good, old-fashioned communication goes a long way in building better physician-patient relations, which, in turn, can help you to build a stronger practice. Surveys show that physicians who take the time to talk to their patients not only have happier and more satisfied patients — these patients go out and tell their friends and neighbors, thus building the practice.

Likewise, those physicians who are highly visible in their communities — through volunteer work, speakers bureaus, health fairs and seminars, community service projects, newspaper columns, TV and radio spots, etc. — can make major gains in attracting new patients to their doors.

This article is designed to help you discover new and better ways to communicate with your current and future patients — to "market your practice," in the lingo of the day.

Like all aspects of medicine and society today, it's not nearly as easy as it used to be. And it is highly unlikely that physicians will ever again have the luxury of simply hanging out a shingle and sitting back and waiting for the phone to ring.

The trade-off, however, can be better physician-patient relations, which will not only go a long way to improve the quality of health care for patients, but can also make the practice of medicine more rewarding, enjoyable and professionally satisfying for physicians.

What Is Marketing?

For many, the word "marketing" conjures up the image of a high-pressure salesman trying to pawn off his wares or services on poor, unsuspecting



Marketing is an ongoing process of finding out what your patients want, what they perceive their needs to be and then matching your services to meet those needs . . .

clients or customers. In medicine, what frequently comes to mind is the snake oil salesman pushing potions, lotions and other worthless concoctions from the back of a pick-up truck.

It is little wonder, therefore, that many physicians find marketing distasteful — without ever taking the time to discover what marketing really is or what it can do for a medical practice.

Marketing today is a highly sophisticated discipline taught in the best universities and colleges throughout the country and practiced by successful businesses, institutions and industries everywhere. It is an essential component in a capitalistic society where competition — not government — determines who will survive and who will not. Thus, as competition continues to increase in the health-care arena, so will the need to develop new and better business and marketing techniques designed to make sure your practice will be one of the survivors.

In plain and simple English, marketing in medicine is an ongoing process of finding out what your patients want, what they perceive their needs to be and then matching your services to meet those needs. It is a methodology for becoming more patient-oriented: understanding your patients' personal needs, concerns and problems, as well as their medical conditions. To be a successful marketer you must examine what you currently are doing in your practice today that attracts patients — as well as what turns them away, causing them to schedule an appointment with the physician down the street.

Marketing relates to the way your office is set up, how your receptionist answers the phone, the hours that you keep and the time you spend with your patients. Surveys show that patients judge their physicians not by the amount of knowledge and expertise they possess, but rather by their willingness to answer questions honestly and openly, to explain problems in clear and simple language and to spend time with patients.

Those same surveys indicate, on the other hand, that patients stop seeing a particular physician — not because of incompetence, but because the doctor "didn't have a friendly personality," "didn't spend enough time with me," or "didn't answer questions honestly or completely."

Marketing also involves determining your own personal needs: how many patients must you see in a week in order to cover your overhead and make a profit? How many hours are you willing to work during the evenings and weekends to keep and attract patients? How well are the members of your staff performing and what qualities do they possess and/or lack? Would you benefit from taking in a partner, moving to another location or planning some promotional activities?

And finally, marketing is good planning, a way to analyze what you are doing now and what you would like to be doing in the future. It forces you to take a good, close look at yourself and your practice — and then, to ask yourself, how can you change things for the benefit of you and your patients? It allows you to set up some long-range goals and some specific objectives for reaching those goals.

In essence, marketing is not just a way to assure your practice a place in the health-care marketplace for years to come. It also helps to assure you that your practice is everything you would like it to be, and to assure your patients that their special needs are being considered and met whenever possible.

Examining Your Practice/Gathering Marketing Information

Every good marketing program begins with a careful look at your current situation. Until you know where you are, it is impossible to determine where you want to go. You can spend thousands of dollars hiring a consultant to come in and analyze your practice, pointing out its strengths and weaknesses and helping you to decide how to remedy any problems. However, much can be accomplished by simply asking yourself some key questions about your practice and by analyzing readily available data from your office records and the community. **Who are your patients? Where are they coming from? How do they perceive you?**

Your patients are the lifeblood of your practice. And while they represent a wide variety of personalities, problems and circumstances, you may note that they also have some similarities that could make a difference in your medical practice. For example, if most of your patients are elderly, their needs will be quite different from those of younger families with small children. Likewise, it is vital for you to know how new patients find out about your office, why old patients leave, and, in general, how patients feel about you and your practice.

Some questions to ask about your patients include:

- Who are your patients? What are their ages, occupations and backgrounds? Where do they live and work? How long have they been with you? Why do they continue to see you?
- How many new patients have you seen over the past year? How many have you lost and why?
- How do new patients find out about you?
- What are the most common types of medical problems your patients have?
- How do most patients pay for their care? How many are covered by Medicare or are enrolled in IPAs, PPOs and other alternative delivery plans?
- How responsive are patients to your advice? How frequently do they schedule regular checkups and other means of preventive care?
- Do most of your patients work, or are they retired? Do they drive or ride the bus?
- What are the income levels of your patients? What types of jobs and professions are they in? How well educated are your patients? How sophisticated are they in terms of their own health care?
- Do your patients have a generally positive feeling toward you and your office?
- What types of questions do your patients ask you most frequently? How responsive are they to treatment?
- Do a majority of your patients come from a certain ethnic background? Is English their first or primary language?

To find the answers to these and other questions about your practice, review your patient records. If needed, you may want to revise your recordkeeping system to include this type of information. For example, it is vital for you to know how new patients find out about your office.

It is equally important for you to know how you and the services you and your staff provide are viewed by your patients. A patient questionnaire is an excellent source for this type of information. Patients who may be hesitant to express dissatisfaction directly to you may be more willing to do so anonymously. While not strictly scientific, questionnaires are an excellent tool to help you pinpoint problem areas.



It is vital for you to know how new patients find out about your office, why old patients leave and how patients feel about you and your practice.



A patient questionnaire is an excellent source of information. Patients who may be hesitant to express dissatisfaction directly may be more willing to do so anonymously.

The Ohio State Medical Association produces a patient questionnaire that you can purchase in bulk (see order form on page 774) or you can devise your own questionnaire. Questionnaires can be mailed or distributed to patients as they enter the office. Remember, anonymity is important.

Where is your practice located?

Location, location, location are the three keys to any good real estate investment. Nowhere is this more true than in the location of a business or professional office.

It is important to ask yourself:

- Where is your practice located and how convenient is it to your patients? Is it in a busy commercial area close to shopping and work areas, or in a quiet residential area convenient to your patients' homes? Is it in an economically viable neighborhood or a run-down and depressed part of your community? Is it on a public transportation route, or must your patients drive to be able to reach you?
- Is there adequate parking around your office building and does traffic flow smoothly in and out of the parking lot?
- If you are not on the first floor, are there elevators to aid your patients in reaching you?
- What is the general appearance of the building where your office is located? Is it well-maintained, landscaped and readily visible?
- How large and readable is the sign that portrays the name and address of your practice?
- Is your office easy to find in the building or complex?

One good method of analyzing your patients geographically is by pinpointing them by zip code (or street) on a city map. This helps you determine where your patients are coming from and judge the convenience of your office to these patients. Also, try approaching your office as a patient would approach it. See for yourself how convenient parking is and how identifiable and easy-to-locate your office is. Remember, you don't want a frustrated patient walking into the office.

What hours are you available?

Again, depending on the circumstances, availability can be a key issue in drawing — or in turning away — patients. If your patients are older and prefer to be seen during regular weekday hours, scheduling evening and weekend appointments may not be necessary. However, if you are working with a younger working population, some early evening and Saturday hours are essential to accommodating their needs.

Before setting your hours, it is important for you to know the wants and needs of your patients. Ask yourself:

- Are you able to schedule patients at times that are convenient for them — evenings and weekends, if necessary?
- Are you or a partner available on a 24-hour emergency basis?
- When you are out-of-town, ill or on vacation, is someone covering for you?
- How far ahead must patients schedule their appointments?

How comfortable is your waiting room?

Even on the best of days when everything is going smoothly, your patients will spend some time in your waiting room. Even if their stay is a brief one, the appearance of your reception area says a lot about you and your practice.

- What image does your reception area portray? Are the furnishings sleek and modern, conservative and traditional, or informal and homey?
- Does your office decor lend itself to the type of patients you

see? For example, if you draw a lot of teens, do pictures and furnishings reflect a youthful age group?

- What types of books, magazines and other publications are available for your patient to read while they wait?
- Is adequate lighting available for reading?
- Are signs regarding office hours, insurance and fees clearly yet tastefully posted?
- Are your furnishings comfortable and arranged to afford some privacy?
- Do you have a private area available for the discussion of fees, insurance forms, etc.?

But in the effort to make your reception area comfortable, keep in mind that your goal is to keep to a minimum the amount of time patients spend in this area. If you want to know how patients feel about the time they spend cooling their heels in your waiting room, read Dear Abby. This waiting time is probably one of the biggest sources of frustration for patients.

If you *routinely* keep patients waiting for 30 minutes or more, you may need to reevaluate your scheduling system. Obviously, emergencies occur and, when this happens, it is important to let waiting patients know and give them the option of rescheduling. Most patients will be understanding if you apologize and explain the delay.

How friendly is your staff?

A friendly, courteous staff can go a long way toward helping your patients feel comfortable and at home. Likewise, a curt or thoughtless receptionist or an unfriendly staffperson can turn patients against you before they ever get to see you.

It is important for you to know:

- Does your receptionist immediately greet patients upon entering in a friendly and cheery manner?
- Do your staffpeople treat patients in a friendly and courteous manner?
- Do the jackets or uniforms worn by staff members reflect the type of image you would like your practice to portray?
- Are staff members willing and able to assist your patients with personal and financial questions, as well as with professional matters?
- How long does it take for your staff to answer phone calls? (People start feeling uncomfortable after the third or fourth ring.) Are patients left waiting on hold for long periods of time or forced to call back repeatedly?

A patient questionnaire can help you pinpoint problems within your staff. Also, having a friend or relative pose as a patient can give you invaluable insight into the day-to-day operation of your office.

Are you earning a living?

Even if you have the most loyal patients, the finest location, the most convenient office hours, the best decorated reception area and the friendliest staff, your practice will not last long if you are not able to earn a living from it. Yet if your fees are too unreasonable, your patients may seek their health care somewhere else.

OSMA offers brochures, newsletter for use in your practice

The Ohio State Medical Association has two brochures and a newsletter available to you to help you attract new patients and keep current ones.

"Partners in Good Health" is a brochure that can be personalized to your individual practice and handed out or mailed to your patients. It covers common topics such as telephone calls, appointments, confidentiality, fees and insurance. There's room for a short paragraph on your background and training, your office hours, special services, hospital affiliation and emergency instructions. "Partners in Good Health" will ensure that the information your patients need will be at their fingertips.

"Now's Your Chance . . . to let us know how you feel about your health care" is a short patient questionnaire in a brochure format. It will help you find out such things as how your patients feel they are treated by your office staff, and if they feel they have to wait too long to see you when they make an appointment.

The questionnaire is designed as a self-mailer, and patients are not required to sign their name. "Now's Your Chance . . ." can be a valuable tool to keep your finger on the pulse of your practice from your patients' point of view.

The OSMA can also offer you a custom-designed health education newsletter you can hand out or mail to your patients on a quarterly basis. "Health Hints" covers topics of interest concerning general health such as exercise, nutritious eating, how to make your home safer and much more. Your name, address and phone number are on every issue they receive.

To receive a free sample of each pamphlet and "Health Hints" or to order a supply, see the ad on page 774 of *OHIO Medicine,* or call the OSMA's Department of Communications and Physician Marketing at (614) 228-6971.

Tips on Marketing Your Practice from the OSMA



What do I do in an emergency?

Can I get a prescription refilled over the phone?

These, and other questions, are commonly asked by your patients. You can make sure your patients get all the answers they need by ordering the brochure "Partners in Good Health" from the OSMA Department of Communications and Physician Marketing. "Partners in Good Health" is personalized to your individual practice, so you can be sure your patients receive the kind of information they'll need.

Ordering Information:

$30 for the first 100 brochures ordered
$15 for each additional 100 ordered

Does your office phone ring more than six times before it gets answered?

Do your patients usually wait longer than 30 minutes to see you for an appointment?

If you answered "I don't know" then you need the brochure "Now's Your Chance...to let us know how you feel about your health care". This brochure is actually a simple, short, patient questionnaire. You can mail them out or hand them out to your patients, then use the information you get back to improve your practice...and more effectively market it to new patients.

Ordering information:

$15 for 100

The OSMA also has a personalized health education newsletter you can hand out or mail to your patients on a quarterly basis. "Health Hints" gives your patients information on healthy eating and exercise habits, how to reduce their chances of injury and illness, and much more.

Ordering information:

$25 for 100 up to 600
$22 for every 100 above 600

For your free sample brochure, or to order a quantity, contact:

The Ohio State Medical Association
Department of Communications and Physician Marketing
600 S. High St. Columbus, OH 43215
Phone: 614-228-6971

Ask yourself:

- How do your fees compare to those of other physicians in your area and specialty?
- What discounts are you currently offering patients enrolled in alternative delivery plans such as PPOs and IPAs? How is this affecting your income?
- What types of examinations, tests and procedures do you perform most frequently? Are you being adequately runumerated for these?
- What percentage of your patients are not covered by insurance or are unable to pay for their care?
- What billing and collection procedures do you use to make sure that fees are paid in a timely manner?
- Are you paying too much money for office space, overhead, staffing, telephone service, etc.?
- Have you taken the time to explain to your patients why certain examinations and procedures cost what they do?
- Are you willing to discuss finances with your patients in a helpful, yet forthright manner?

Who is your competition?

The way you practice medicine can be heavily influenced by the competition that surrounds you. For example, if you are the only physician in a small community which is several miles from another town, you may have little trouble attracting and keeping the patients you need to earn a living — and you may be able to set your own terms.

If, however, a new HMO or Urgent Care Center has opened right around the corner — or a new group of physicians in your specialty has set up practice across the street from you, it changes the picture considerably.

It is important for you to know:

- How many physicians in your specialty practice are located within a five-mile radius of your practice?
- If an HMO is located nearby, what percentage of the patients in your community are enrolled?
- Are most physicians in your community enrolled in an Independent Practice Association (IPA) or some other alternative delivery plan? Are you?
- Do you get a significant number of referrals from other physicians in your area?
- Does your hospital or county medical society promote your practice through a physician referral service?
- What are the going fees for the types of services you render? How do your fees compare to these?
- How active is your competition in promotions and advertising? How active are you by comparison?

Diagnosing Your Problems

Once you've taken the time to thoroughly examine your current practice situation, you can begin to identify some of the problems you may be having with your patients, your location, your hours, your office, your staff, your finances, your competition and your public image. Again, this may require the help of an expert. But in many cases common sense can dictate what may be wrong and how you might fix it.

For example, let's say you are an ob/gyn who has enjoyed a busy practice in the past but you suddenly find yourself with more free afternoons than you want. Your practice is in an old, established neighborhood in the community. While it may have been an ideal location for young families 10 or 20 years ago, today, the population surrounding you is older and your deliveries have substantially declined.

Or let's say you are a pediatrician located in an up-and-coming neighborhood with lots of young families — and yet you don't seem to be getting your share of the patients. In the past, you've never had to worry about evening or Saturday hours — but suddenly you find that more and more young mothers in your immediate vicinity are demanding after-hour care because they are working and their children are in day-care.

Maybe by all current standards you are in a good location — but you seem to be losing patients right and left. One of the major employers in your community has contracted with a Preferred Provider Organization (PPO) for all health-care services, and you are not a member of that plan.

Or, you're seeing as many patients as you can comfortably squeeze into the day, but you just don't seem to be making enough money from your practice.

The solution to these and other problems are varied and many. For example, if you would like to keep your ob/gyn practice in the current, established neighborhood where you have been for the past 10 years, you may want to shift the emphasis of your practice from obstetrics to gynecology. You could plan some seminars on common gynecological problems experienced by older women, or buy some new equipment for conducting mammography screening.

If, on the other hand, you want to continue delivering babies as the base of your practice, a move to a neighborhood populated by younger families may be in order. If these families consist of mostly working couples, however, you may have to plan regular evening and Saturday office hours. If the majority of these families are enrolled in PPO, a HMO or IPA plan, you may have to consider becoming a member.

continued on page 777

Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health-Care Workers and Allied Professionals

Editor's note: *This is the second in a series of AIDS guidelines and precautions prepared by the Centers for Disease Control, and run in* **OHIO Medicine** *at the suggestion of the OSMA AIDS Task Force.*

Acquired immunodeficiency syndrome (AIDS) was first recognized in 1981. The epidemiology of AIDS is consistent with the hypothesis that it is caused by a transmissible infectious agent.[1-3] AIDS appears to be transmitted by intimate sexual contact or by percutaneous inoculation of blood or blood products. There has been no evidence of transmission by casual contact or airborne spread, nor have there been cases of AIDS in health-care or laboratory personnel that can be definitely ascribed to specific occupational exposures.[4]

CDC has published recommended precautions for clinical and laboratory personnel who work with AIDS patients.[5] Precautions for these and allied professionals are designed to minimize the risk of mucosal or parenteral exposure to potentially infective materials. Such exposure can occur during direct patient care or while working with clinical or laboratory specimens and from inadvertent or unknowing exposure to equipment, such as needles, contaminated with potentially infective materials. Caution should be exercised in handling secretions or excretions, particularly blood and body fluids, from the following: (1) patients who meet the existing surveillance definition of AIDS[1]; (2) patients with chronic, generalized lymphadenopathy, unexplained weight loss, and/or prolonged unexplained fever when the patient's history suggests an epidemiologic risk for AIDS[1,2]; and (3) all hospitalized patients with possible AIDS.

These principles for preventing AIDS transmission also need to be adopted by allied professionals not specifically addressed in the previous publications but whose work may bring them into contact with potentially infective material from patients with the illnesses described in the above three groups.

The following precautions are recommended for those who provide dental care, perform postmortem examinations, and perform work as morticians when working with persons with histories of illnesses described in the above three groups.

DENTAL-CARE PERSONNEL

1. Personnel should wear gloves, masks and protective eyewear when performing dental or oral surgical procedures.
2. Instruments used in the mouths of patients should be sterilized after use.[5-9]

PERSONS PERFORMING NECROPSIES OR PROVIDING MORTICIANS' SERVICES

1. As part of immediate postmortem care, deceased persons should be identified as belonging to one of the above three groups, and that identification should remain with the body.

2. The procedures followed before, during, and after the postmortem examination are similar to those for hepatitis B. All personnel involved in performing an autopsy should wear double gloves, masks, protective eyewear, gowns, waterproof aprons, and waterproof shoe coverings. Instruments and surfaces contaminated during the postmortem examination should be handled as potentially infective items.[5-7]
3. Morticians should evaluate specific procedure used in providing mortuary care and take appropriate precautions to prevent the parenteral or mucous-membrane exposure of personnel to body fluids.

These and earlier recommendations outline good infection control and laboratory practices and are similar to the recommendations for prevention of hepatitis B. As new information becomes available on the cause and transmission of AIDS, these precautions will be revised as necessary. **OSMA**

Reported by AIDS Activity, Div of Host Factors, Div of Viral Diseases, Hospital Infections Program, Center for Infectious Diseases, Office of Biosafety, CDC

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AZT EMERGENCY FUND

Beginning September 1, 1987, federal funds will be available through the state to cover the cost of AZT/Retrovir and any other drug found by the Federal Food and Drug Administration (FDA) to prolong the life of an individual with acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC). The AZT emergency fund will be available for one year only to eligible low-income individuals.

To be determined eligible by the Ohio Department of Human Services, an individual must:

- have current monthly income of less than $1,020, or $1,530 for a couple plus an additional $510 for each dependent;
- *not* be covered by Medicaid or other third-party payor that reimburses for the cost of AZT;
- meet the medical indicators for the use of AZT as certified by a physician and the approval of the drug's supplier, Burroughs-Wellcome (while their review process is in effect).

Claims for payment from the AZT Emergency Fund are to be submitted on the Universal (*not Medicaid*) claim form to:

Jerome E. Friedman, Chief
Bureau of Medicaid Policy
Ohio Department of Human Services
30 East Broad Street — 31st Floor
Columbus, Ohio 43266-0423

Claims for AZT under this program will be reimbursed at the Medicaid rate.

FOR APPLICATIONS AND FURTHER INFORMATION, CALL THE AZT HOTLINE:
1-800-282-1190 extension 6420 or 466-6420
8:00 a.m. to 5:00 p.m. Monday thru Friday

Packaging your practice . . .

continued

Some problems may not be so readily apparent or easy to diagnose — or your practice may be suffering from a variety of conditions that are leading to its overall illness.

And even if you know what's wrong, finding solutions to your particular set of circumstances may not be all that easy. Again, in some situations it may be worth your time and investment to seek some professional help for your problem. Agencies that specialize in marketing can research your particular area, conduct both internal and external audits of

continued on page 785

Medical Student Impairment — A Growing Problem?

By Stacey Hollaway

OHIO Medicine has given the OSMA-MSS an opportunity to voice student concerns. One issue the OSMA-MSS wishes to address is student impairment. According to recent federal regulations, all medical schools must have working impairment programs in order to receive financial aid.

A study of alcoholic physicians found that over 50% graduated in the top third of their class, 23% in the top tenth and 5% in the bottom third.[1] A study by Clark[2] found 30% of the medical students had met the criteria for alcohol abuse during their education, 12% within the last year, with 52% reporting never having suffered major impairment from drinking. In the same study[2] it was found that 73% of the students had used marijuana, 28% cocaine, 25% stimulants, 22% tranquilizers and 13% narcotics. Impairment involves both physical and psychological factors. The AMA has recognized the high suicide rate among medical students, residents and physicians by preparing a study of the feasibility of starting a suicide prevention program (Resolution 17 A-86). According to studies by Ross[3] and McGee,[4] suicide is the second leading cause of death among medical students. To address this problem, *A Primer on Medical Student Impairment* was developed by the AMA-MSS in 1986. This primer contains information on what impairment is, the scope of the problem, signs and symptoms of impairment and an outline of Louisiana State University's impairment program, The Phoenix Society. The University of Tennessee's impairment program, Aid to the Impaired Medical Student (AIMS), was also fully operational at this time.

At the OSMA-MSS Annual Meeting in February of '87, Resolution 8 was passed unanimously by the House. Resolution 8 deals with surveying the medical schools' existing impairment programs in order to define the scope of the problem and to establish a working referral for schools that want to develop school-based impairment programs. Resolution 8 was spurred by the growing number of medical students who are impaired and the lack of appropriate medical student impairment programs. The deans of the medical schools will be surveyed during September, with the results to be published in the December issue. The hope of this survey is to encourage all medical schools to develop effective impairment programs. In the fall of '86, students at Ohio State University's College of Medicine and the Northeastern Ohio Universities College of Medicine began developing student impairment programs that would convey love and support. Among the obstacles these programs must overcome are the misconception that impaired students are having academic difficulties, the fear students have of being their "brother's keeper" and the liability issue.

The results of the OSMA-MSS Medical School Impairment Survey and other articles on student concerns and activities will be published in upcoming issues of *OHIO Medicine*. The OSMA-MSS would like to thank the members of the OSMA's Committee on Impaired Physicians for their continuing support. The OSMA's

Resolution 8 was spurred by the growing number of medical students who are impaired and the lack of appropriate medical student impairment programs.

Committee on Impaired Physicians has extended an invitation to all medical schools inviting one student representative from each school to be a committee member. Currently the OSMA-MSS is looking for interested students from Case Western Reserve's School of Medicine, Medical College of Ohio and University of Cincinnati's School of Medicine.

For more information, please contact: Michael Aruta, OSU, Runaway Bay Dr., Columbus, Ohio 43204 and/or Stacey Hollaway, NEOUCOM, 12821 Beeson St., Alliance, Ohio 44601-representatives to the OSMA's Committee on Impaired Physicians and the OSMA-MSS Committee on Impaired Medical Students. **OSMA**

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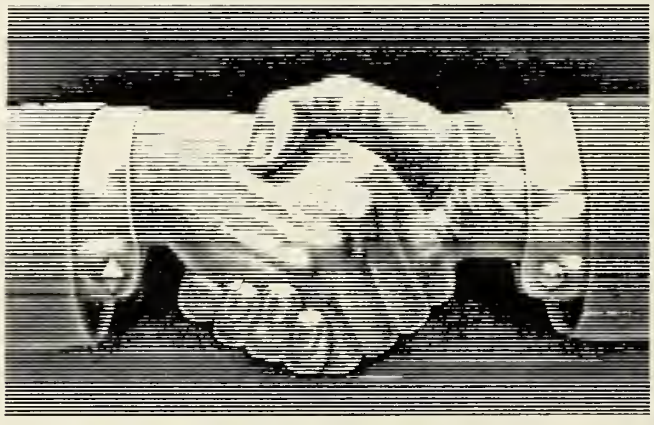
Medical student substance abuse: a new study

Drug abuse by physicians and medical students is a sensitive and important issue for the medical profession and society. In a major report on physician impairment, the AMA's Council on Mental Health stated, "Of particular concern for the future are the incidence of use of, and the attitude toward psychotropic substances among medical students and physicians in training." All 50 states currently maintain impaired physician committees or equivalent structures. Several medical schools are developing similar programs for their students. It is unclear, however, how many medical students use or abuse psychoactive drugs. Further epidemiologic information is necessary to measure the actual prevalence of drug use and to determine the success of prevention and treatment programs.

Our survey of a Midwestern medical student population is based upon cross-sectional surveys from three consecutive years. Although our study was designed to measure psychoactive drug use, we found that caffeine is overwhelmingly favored by medical students for daily use. It is followed by alcohol and non-prescription medications. Alcohol still holds an important position as the "social lubricant" among our medical students. This is seen in its direct correlation to social hours and extraversion scores on the EPI. However, we found markedly lower psychoactive drug use, compared to other studies, which suggests that regional influences — higher population density, for example, greater availability of drugs, increased competition and pressure to perform, combined with more favorable social attitudes toward drug usage in these settings, may be responsible for higher reported current drug usage than academic influences.

We suggest that epidemiological information on medical student drug usage taken from other regions of the country should only cautiously be applied to estimate medical student drug use in the Midwestern states. Careful consideration should be used when applying this information to implement medical student drug prevention and to assess progress measurements of medical student impairment programs. Our findings also suggest that alcohol consumption is quite prevalent and should be of primary importance in drug impairment programs in this region. — *Brendan T. Carroll, MD; Kathleen S. Franco, MD and Marijo B. Tamburrino, MD*

STRONGER THAN EVER— the T&S commitment to OSMA members!



Working hard on behalf of OSMA members is a commitment Turner & Shepard takes seriously. Our objective is to keep our service ever more responsive - and to keep the OSMA's sponsored insurance plans responsive to members' needs.

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Melanomas and Nevi

By James J. Nordlund, M.D. in cooperation with the Ohio Dermatological Association

The incidence of melanomas in the United States is increasing annually. About 6,000 U.S. citizens will die this year from melanoma. It is thought that this higher incidence is due to the more frequent and prolonged exposures of individuals to high-intensity sunlight during outdoor recreational activities. The problem of melanomas should be particularly distressing to medical practitioners. Melanomas are curable if identified early in their course and treated by appropriate surgical excision. Delay in diagnosis or improper therapy seriously jeopardizes the probability of achieving a cure by total excision of the primary lesion. It is metastatic melanoma that is so difficult to treat, not the early primary lesion. Melanomas are like many other cancers, rarely curable in their advanced stages and minimally responsive to currently available therapeutic modalities. The consequence of missed diagnosis is tragic both for the patient and the physician. The patient dies, the ultimate tragedy.

How do we avoid missing melanoma? "Managed medical care," i.e., cost containment policies, do not allow for indiscriminant testing or unnecessary surgical procedures. Even before the recent implementation of cost containment policies, it was not, and still is not, practical to remove any and all moles or pigment spots from all patients.

There are ways to assist the medical practitioner in attacking the problem of moles, melanomas and nevi. First, we must identify those individuals who have a high risk of developing melanoma. Secondly, we must instruct them to examine their skin for signs of melanoma. Third, the physician, if not an expert, must seek the assistance of his colleagues, both for clinical evaluation of the lesions and for the proper interpretation of pathologic changes in the biopsy specimens.

I. Risk Factors and Early Signs of Malignant Transformation to a Melanoma

A. Skin Color and Sunlight

Melanomas can afflict any person. No one is immune. However, some individuals are more at risk and they need to know that. Individuals with black skin have a rather low propensity for developing a melanoma. Black-skinned patients typically develop melanomas on the sides of the soles, on the palms or in the mucous membranes of the head and neck. Any ulcer, sore or growth on the palms or soles of a black-skinned patient should alert the physician to the possibility of a melanoma.

Melanomas in blacks are rare, about one or two per 100,000 black individuals per year. Only about 200 blacks in the U.S. each year will develop melanoma. Any individual with dark hair and dark brown eyes is at lower risk than other individuals with blond or red hair and blue or hazel eyes. The latter people are usually of Northern European or Celtic ancestry. Many, if not all, develop freckles in response to exposure to sunlight. Sunlight is one important agent which contributes to development of melanomas. Thus these patients with light complexions should be much more cautious about excessive sun exposure or the use of artificial tanning parlors. They should be encouraged to wear when out in the summer sun (or in the southern climates near the equator) broad-rimmed hats, thin yet long-sleeved clothing and liberal amounts of sunscreen.

B. Prophylaxis

There are many sunscreens on the market, each labeled with a sun protective factor (SPF). The SPF ranges from 2 to 25. Midsummer sunlight at noon will cause a mild burn in the fair-skinned patient after about 15 minutes exposure. Sunscreens that increase the exposure time needed to cause a burn from 15 to 30 minutes have an SPF of 2. A sunscreen that provides protection against burn for 180 minutes (12 times longer) has an SPF of 12. Fair complexioned patients should be encouraged to use sunscreens with high SPF's (12-15 or greater).

Patients who have darker complexions and tan readily can get by with less protection. During spring and summer, all patients should apply the sunscreen on all exposed areas of skin — the face, trunk and extremities — daily, in the morning before going outside and again during the day after swimming or bathing. Patients possibly increase their risk for melanomas by frequenting tanning parlors of any type.

C. **Self-examination**

Each month all patients, but especially those with light skin, should examine their entire integument. What should they look for? The answer is change, but that single word has complex meaning. Everyone acquires new nonmalignant moles beginning at the age of six to 12 months of life. The process continues through ages 40 to 50 years. After this time, moles begin to disappear spontaneously. Thus, not every change in a pigmented spot or mole means cancer. Changes which are clinically apparent in a three to six month period of time are always suspicious.

Melanomas often change in diameter. That is, melanomas will enlarge in diameter. Less commonly, melanomas begin to regress and their diameter can shrink. Both enlargement and reduction are changes.

Melanomas may change from a flat spot to a raised papule. But if the lesion undergoes a regression, the nodule may flatten down. Melanomas often change from being light in color to moderate brown or to deep black, blue-black, or red and blue. On the other hand, some melanomas lose their color (become amelanotic). Bleeding, itching or sudden appearance of a new pigmented spot should alert the patient to consult his or her physician. The physician should remove it and *always* send the specimen to a knowledgeable pathologist, preferably a dermatopathologist. Ideally, the entire presenting lesion should be excised. This may be difficult if the lesion is large and present on the face or other cosmetically-important areas. If the lesion is obviously a melanoma, the patient should be referred to a physician with the surgical skills to remove it completely with minimal cosmetic deformity. The pathologist needs the entire lesion to evaluate it properly.

More commonly, the clinical diagnosis is not so obvious. The physician is suspicious but not certain the legion is malignant. The physician should probably seek assistance from colleagues who have had extensive experience with nevi and who can assist in deciding if an excisional or incisional biopsy is appropriate. If the lesion seems likely to be benign and cannot be totally removed without cosmetic disfigurement, a small, deep (3-4 mm) incisional biopsy is appropriate.

D. **Interpretation of the Tissue**

Interpretation of melanoma in a histologic section can be very difficult. Some lesions are obviously malignant; others are obviously benign. However, a melanoma must be distinguished pathologically from a juvenile melanoma (Spitz nevus), a spindle cell nevus, a blue nevus, a congenital nevus, or a dysplastic nevus, all of which are benign. The treatment of choice for a melanoma is wide surgical excision. The width or size of the excision depends on the thickness of the melanoma. The other benign lesions named above require no particular therapy or a minimal excision. It is the primary physician who has the responsibility to be sure that his pathologist has experience to interpret correctly the changes observed in the tissues. For example, a benign mole partially removed by shave biopsy can grow back to its original size. The nevus, if removed and examined histologically, may resemble a melanoma. However, the lesion in fact is benign. Often such a lesion is called a pseudomelanoma. It is the responsibility of the primary physician to provide the pathologist with the appropriate clinical information in order for him to interpret the histologic changes correctly. The primary physician is also required to ensure that the surgeon knows the proper type of excision the lesion requires. The size of the excision and the prognosis for recurrence are based on the Clark and/or the Breslow leveling systems. Thin melanomas (those less than 0.75 mm in greatest depth) require smaller excisions than thicker lesions (those 1 mm or greater in depth). The goal is not to do excessive or disfiguring surgery on patients with benign lesions or melanomas which have no propensity to metastasize. On the other hand, one must be certain to remove entirely if possible a melanoma with a high risk of recurrence.

II. **Other Risk Factors**

A. **Congenital Nevi**

Often nevi are considered congenital because a patient states "That mole has been there all my life." In fact, the patient rarely knows if the lesion was present at birth. The definition of congenital means "present at birth." Careful questioning will usually prove that the patient knows only that the lesion was present from early childhood, for example from age 4 or 5 years. Such a lesion may not be a congenital nevus. The

distinction is important because congenital nevi, i.e., those observed by a physician or parent to be present at the time of birth, may be more susceptible to malignant transformation than moles acquired a few months later when the child was only six or seven months old.

The term congenital does not mean genetic. Congenital nevi are developmental anomalies. In only one family has there been a suggestion of an inherited tendency to develop this type of lesion. There are a few cases reported in which one of two identical twins has been afflicted with a congenital nevus. This would confirm the concept that congenital nevi are not genetic in origin but are developmental anomalies. About 1 to 1½ percent of all neonates have a nevus on the skin at the time of birth.

Large congenital nevi are defined as those nevi which are 20 cm or greater in diameter. Some nevi may cover the trunk or most of an infant's integument. Large congenital nevi are considered to have approximately a 5 to 7 percent chance of malignant transformation. The melanoma can develop at any age from childhood through adulthood. Most melanomas affecting prepubertal children arise in large congenital nevi.

Some of the lesions cannot be removed because they are too extensive for any type of surgical procedures. Others, for example a nevus that covers much of the back, can be removed by plastic surgeons in multistage procedures, some of which require grafts. This surgery should be started around one year of age when the child is at a relatively low surgical risk but before the infant develops a melanoma. The cosmetic results are never great. But the risk of malignancy and mortality rate are too high to ignore these lesions at any age.

Congenital nevi can be smaller than 20 cm, sometimes as small as 1 cm in diameter. There are no definitive data on the risk of such lesions becoming malignant. Some investigators strongly believe all congenital nevi are premalignant. Others suggest the propensity for malignancy in these type lesions is no different than that of acquired nevi. The results of one preliminary study suggest that small nevi may be more risky, although the data are not adequate to make any absolute conclusions. The investigators studied the quantity of DNA in the nevus cells of congenital nevi. Malignant cells tend to have an aneuploid quantity of DNA, that is, not the normal complement of DNA present in 46 chromosomes. Cells from a few congenital nevi greater than 1.5 cm in diameter, had an aneuploid amount of DNA, that is, maybe carried a greater risk for malignancy. This finding is far from definitive, but is consistent with the concept that the congenital nevus cells have a biochemical defect that may make them more susceptible to malignancy. These smaller (less than 20 cm) congenital nevi are easier to remove and the results often improve the cosmetic appearance. Most investigators advise prophylactic removal. If the patient refuses, the lesion must be carefully observed. The smallest lesions, 1.5 cm or less, are so easily removed that the risk of surgery seems far less than any potential risk from cancer. This approach is not biologically satisfactory as a final answer, but at this time is the best solution to a difficult problem.

B. Dysplastic Nevi

Dysplastic or atypical nevi have been formally recognized as a predisposing cause for melanoma only in the last 10 to 12 years. The credit for description of dysplastic nevi goes to Wallace Clark and his colleagues who studied two kinships in which many individual family members had numerous bizarre appearing nevi and one or more melanomas. The original term was the B-K nevus syndrome (B and K are the first initials of the two family surnames). Later it was found that the syndrome was much more common than previously suspected and that there were many kinships in which individuals exhibited atypical nevi and a high propensity for melanoma. This is the *familial* form of dysplastic nevus syndrome.

A number of studies have now been completed which confirmed that 5 to 7 percent of the population at large have dysplastic nevi. This is the *sporadic* form of dysplastic nevus syndrome. It is my clinical impression, confirmed by several colleagues, that familial or sporadic dysplastic nevi are found almost exclusively in individuals with fair skin, often with Celtic inheritance, who freckle following sun exposure, have red, auburn or brown hair and blue or hazel colored eyes. Dysplastic nevi seem much less common in black or orientals.

Normal, acquired nevi are 2 to 5 mm in diameter, round, evenly colored and tan to dark brown in color. Dysplastic nevi are often 5 to 20 mm in diameter, irregular in shape, multicolored, and exhibit shades of red, tan, brown and black. They are usually located on the trunk and sometimes the extremities, but not infrequently are also found in unusual places such as between the toes, the intergluteal fold, or on the perineum. The histologic features of dysplastic nevi can be divided into epidermal and dermal

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components. Within the epidermis there are nests of nevus cells which show bridging between the rete pegs and the nevus cells themselves are somewhat atypical in their morphology. Within the dermis, one observes mononuclear cell infiltrate and fibroplasia. Sometimes the features are subtle and require a very experienced dermatopathologist for correct interpretation. It is critical to note that in patients with dysplastic nevi, about 10 percent of the nevi that appear clinically abnormal are histologically normal. Thus, to make the diagnosis, it is necessary to remove three or four lesions and have them examined histologically.

The familial form of dysplastic nevus carries a significant risk for development of a melanoma for all affected family members. Not everybody in the kinship will exhibit dysplastic nevi. The absolute risk is not known, but is far higher than the one to 400 risk of melanoma for the population at large. It has been suggested that 25 to 50 percent or more of members of a kinship with dysplastic nevi may get a melanoma. Fortunately they tend to be found earlier in their course and carry a better prognosis. Clearly, the physician must inquire if an individual's primary family, namely children, siblings, parents or grandparents, have either dysplastic nevi or a melanoma. A positive family history for melanoma and the presence of clinically atypical nevi confirmed by histologic examination are criteria for the diagnosis of familial dysplastic nevus syndrome.

Individuals with the familial dysplastic nevus syndrome should not be overwhelmed or terrified by threats of doom and death. They should be informed of the potential risks. Sunlight seems to be an important factor in increasing the incidence of melanoma. Patients with familial forms of dysplastic nevi should be instructed in the appropriate use of sunscreens and cautioned against abuse of sun exposure. The physician should photograph the lesions as a baseline record. Patients must be instructed to examine their integument about once a month. An experienced physician should repeat the examination at four to six month intervals. Any perceived changes in a mole is an indication for its removal and histologic examination. If malignant, appropriate surgical therapy is required. The patient needs reexamination at these frequent intervals for the remainder of his or her life.

Most patients have sporadic forms of dysplastic nevi. That is, they have dysplastic nevi but no family history of melanomas. The risk of developing a melanoma in the sporadic form is not known, but probably lower than in the familial form. These patients are given similar instructions, photographed and followed appropriately at six to twelve month intervals unless they observe a mole undergo a change. Unusual nevi in these patients also should be removed and examined histologically.

Heroic measures to remove all dysplastic nevi are not appropriate. In individuals with dysplastic nevi, melanomas often arise not from the nevus, but from skin that appears normal. In addition, patients with dysplastic nevi acquire dozens of new nevi until advanced adulthood. Following removal of all dysplastic nevi, the patients will acquire many more. Selective removal of worrisome lesions, those appearing malignant or undergoing change, at the earliest possible moment seems the most reasonable approach to caring for these individuals.

III. Conclusion

We can serve our patients best and cut the mortality from melanomas greatly if both the physicians and the public are properly informed. Rather than allowing patients to be frightened away because they are afraid that melanomas are incurable, we need to inform our patients that early diagnosis is the key to a cure. A thorough and thoughtful approach to pigmented lesions can improve the probability that our patients will arrive at medical care early and be cured of their cancer. Physicians can avoid indiscriminant, costly and cosmetically disfiguring surgical excision of benign pigmented lesions.

James J. Nordlund, MD, is Professor and Chairman, Department of Dermatology, University of Cincinnati College of Medicine.

Packaging your practice . . .

continued

your practice and help you to devise an overall plan for remedying those problems.

Still, it is important to keep in mind that the most crucial element to the overall well-being of any medical practice is the physician-patient relationship, and there are a variety of ways that you can strengthen your relationships with both current and potential patients without spending a nickel. Other methods may require a minimum financial investment, while some will require that you budget ahead — yet they may bring you considerable returns for the amount of money they cost you.

Next month watch for the marketing column that will feature with an article telling you how to treat your practice's problems.

Wright State School of Medicine Students Volunteer

By Robert Mott, Jr.

Training future physicians to understand the needs of disabled patients is the basis of a program that has recently been implemented at the Wright State University School of Medicine by the Community Service Committee. The committee received several programs authored by the Montgomery County Board of Mental Retardation and chose to involve medical students in the recreational services for two reasons. First, virtually no formal training is required to play with a child with a disability or take a person with a disability to the zoo. Second, the usual uneasiness that many people experience during their first contact with these people is reduced when the activity they are participating in is enjoyable and familiar to them. Who wouldn't rather play basketball with a child who has Downs Syndrome than try to do a complete history and physical on him? Thus the main goal of the volunteer program is to instill in the medical student familiarity and confidence in working with individuals who are disabled.

The medical student volunteer program begins early in the fall quarter with an orientation talk given by the Recreation and Social Integration Specialist and the Respite Care Coordinator from Family Support Services of the Montgomery County Board of Mental Retardation. The goal of this brown-bag talk is to introduce the medical students to the functions of the board and to highlight programs they may participate in. The volunteer programs that are discussed during the talk include respite care certification, weekend respites and the annual zoo trip.

Respite-care certification is an in-depth, eight-hour workshop offered to members of the community who wish to be certified as respite-care providers. After being certified, those people may go into the home and provide care for the family member with a disability while other family members run errands or take a well-deserved day off. Topics covered at the workshop include feeding, communication, lifting and carrying, first aid and medications, sexuality, recreation and a host of others. Also included is a segment entitled "Trying on a Disability" in which workshop participants attempt everyday tasks while burdened with artificial disabilities. For example, try communicating your name and phone number with four large marshmallows stuffed into your mouth. The results are hilarious yet humiliating and offer insight into the problems faced daily by people who are disabled. The workshop was attended by several medical students last year and was a tremendous introduction to the world of people with disabilities. A workshop is currently being arranged solely for medical students to allow as many as possible to gain this experience.

For those students who did not wish to sacrifice an entire Saturday for the workshop, the Weekend Respite Program was recommended. This program is offered on two Saturdays per month at one of the board-operated schools in the Dayton area. The respites are twelve hours long and are provided to give the families some time off. Respite weekend activities include art and crafts, games, movies and short field trips to local areas of interest. Recent field trips included hiking and a trip to the United States Air Force Museum. Medical students served as Red Cross van drivers, field trip chaperons and activity supervisors back at the school. The medical students were required to stay for a minimum of two hours but were permitted to stay all day if they wished. Nearly one-half of the first-year medical students participated in this program last year.

The big event of the volunteer





Medical students at Wright State University School of Medicine participate in programs which help those with developmental disabilities. A trip to the zoo is just one example of how these medical students are helping out.

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program is a trip to the Cincinnati Zoo. The board provided the proper supervisors, transportation and, of course, the kids. The medical school provided enthusiastic volunteers. The ratio of volunteers to children was approximately 2-to-1 which made for a safe and enjoyable trip. It was difficult to tell which group enjoyed themselves more!

The events previously discussed are firmly in place and serve as the core of this section of the medical school volunteer program. This year the program is expanding to include additional lectures as well as two new weekend programs being offered to individuals with disabilities by the Office of Recreation and Social Integration. These new programs are structured recreational activities that have a written curriculum and are designed for specific age groups. "Let's Play to Grow" is designed for children from birth to six years of age and "Room to Grow" is designed for children from six to 14 years of age. Each session of the program is five hours long and will be offered once a month. Medical students will assist with these new programs.

The Wright State School of Medicine Student Volunteer Program is a dynamic way to familiarize the medical student with the needs and care of a person who is developmentally disabled, while providing valuable manpower for worthwhile community programs. The ultimate goal of this program and other programs developed by the Community Service Committee is to provide the medical student with a variety of experiences which both complement the standard medical school curriculum and result in a more competent, caring physician.

Robert Mott, Jr. is a second year medical student at WSU.

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Editor's note: *This article presents the experiences of Henry Hood, MD, an orthopedist from Lancaster who went to Afghanistan to train rebel troops in proper medical procedures, furthering attempts to restore healthcare services inside this warring nation.*

Eleven Miles From The Border: Aiding Afghanistan

By Deborah Athy

Sandwiched between the Soviet Union, Iran and Pakistan, and not too far from the coveted Persian Gulf region lies Afghanistan, considered "an important piece of real estate," by most of today's powerful countries, says Henry Hood, MD, who practices orthopedics in Lancaster.

While primarily rooted in agriculture, Afghanistan is also oil-rich — making it even more of a prized possession. That helps to explain why, on Christmas Eve 1979, the Soviet Union invaded this neighboring Moslem country. Eight years later, an estimated 115,000 Russian troops still remain.

In response to the Soviet invasion, the Afghan people cultivated a resistance movement "rural in its origin and its persistance," says Dr. Hood. In the beginning, the resistance amounted to farmers throwing aside hoes and shovels and taking up guns — not too far removed from the days of America's own 1775 minutemen militia, he says.

And, indeed, in a picture of these rebel soldiers standing in front of an expanse of mountain peaks, the stereotypical "military look" is absent, replaced instead by loose flowing shirts, dark beards and large turban-like hats — a far cry from the more typical "be all you can be" scenario.

When these rural people first banded together to bear arms, they formed a rather motley crew — loosely formed and disorganized coalitions armed with outdated WWI and WWII weaponry, says Dr. Hood. Since the initial movement, though, the resistance has gone through some fine-tuning and has gained a sense of unity, as well as outside support and more modern artillery.

One result of the Soviet invasion was the disruption of the health-care system, Dr. Hood says. While communist hospitals are operational in some parts of the country, medical care has remained virtually non-existent for the majority of rural Afghans. "Most of these people have never seen a physician," he says.

Malnutrition is a widespread problem and supplies the background to many other diseases, Dr. Hood continues. According to a recent article in *Social Issues and Health Review* magazine: "The devastation of the countryside, especially farmland, has denied the mujahideen (freedom fighters) local food sources, but has also made malnutrition and starvation facts of life for much of the remainder of the Afghan population. The Soviet policy of *rubblization,* accomplished by airdropping mines, high-altitude bombing, or napalming of fields has reduced agricultural production in this primarily rural country to 20 to 25% of prewar production levels."

Left: Afghanistan rebels listen to the medical instructions being given by Henry Hood, MD, Lancaster (second from left).

"The needs of these people are quite different than here, so, mentally, you have to change gears. You go with an open mind, saying, 'How can I help? . . .' "

Thus malnutrition, war injuries and spread of disease from lack of an adequate immunization program all contribute to an ailing health-care system — which is where Dr. Hood fits in. As members of the International Medical Corp. (IMC), Dr. Hood and others are attempting to restore health-care inside Afghanistan. Developed by a UCLA physician in 1986, the U.S.-funded IMC aims to provide health-care services to those areas of the world where the Red Cross won't go.

In addition to the IMC, a number of other groups contribute to the Afghan resistance, including church-affiliated groups, dental and medical specialty organizations, and the French group Physicians Without Frontiers, who actually do their medical handiwork inside the border.

Another program, the U.S. State Department's McCullom Project, flies selected Afghans to American hospitals for medical care otherwise unavailable. Bringing the program a little closer to home, two Afghans recently were sent to Ohio State University for treatment — one with a fractured femur, and the other for a shoulder condition.

Dr. Hood became interested in joining an overseas project around the time that efforts were underway to aid Ethiopia. The time was right in that proverbial cycle of life, he says — of establishing a practice, getting your children through school, etc. And although he maintains a solo orthopedic practice, time away is possible with a little creative scheduling.

Colleagues and friends have been quite supportive, he continues. In fact, he says many physicians show an interest in these kinds of projects. "If you have any inclination to contribute, these groups are a great way to do it," he suggests, adding that there's a surprising amount of flexibility in the types of programs, and that the need for volunteers and support is great.

"The practice of medicine is based on the level of the needs of a particular society," he points out. "The needs of these people are quite different than here, so, mentally, you have to change gears. You can either read up on the situation beforehand or go with an open mind, saying, 'How can I help?' You can't serve the same function over there or you won't be serving the needs of the society."

Thus far, Dr. Hood has made two trips to Peshawar, Pakistan, 11 miles from the Afghan border, to take part in a six-month program to train selected Afghans in becoming advanced medics. He spent six weeks in Peshawar in February/March 1986, and returned last May with 15 other physicians — among them, several surgeons, a pediatrician, anesthesiologist and an ER physician. Dr. Hood and company taught at a medical facility situated on a farm, which included a microbiology lab, operating room and a farmhouse for lodging.

While the farmhouse doesn't boast plush surroundings, neither does it qualify as "roughing it," with comfortable lodging, accommodating weather, fresh water from a deep well, lovely scenery, and wonderful Afghan cuisine with large fresh fruits and vegetables — "you can get anything in a Pakistani marketplace," he adds. To be admitted to the medic program an Afghan must have fought in the resistance movement for two years, and be recommended to the program by a rebel commander. The soldiers, referred to as mujahideen or holy warriors, are usually between 20 and 35 years old. They are called holy warriors because, in many respects, it is a "holy war" that is being waged, says Dr. Hood, explaining that one of the major tenets of the Moslem religion is that those who don't believe in God are the enemy.

The IMC dictates that visiting physicians do not venture inside the Afghan border. Thus, the young medics are prepared to return to their country and perform medical services themselves. "We like to think that by teaching the medics and then leaving them in place, we are setting a foundation for the future," Dr. Hood says.

The medics are introduced to a variety of bread-and butter medical treatments: manipulating medical instruments, IVs, stitches, some anatomy, including the nerves and tissues, and the importance of sterilization, from hand-washing to donning caps, gowns and masks. Special attention is given to treating war wounds and infectious diseases.

Each physician also instructs in his or her specialty; for Dr. Hood, lessons included setting fractures, broken bones, dislocations, and building traction systems with poles and weights.



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Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano R8. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler J8, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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SOUTH ASIA



The students get some hands-on experience by applying their new medical techniques on goats — cleaning and packing wounds or making leg casts and splints, for example.

Down the road from the medical school is a refugee camp of some 700,000 Afghans, providing the young medics with additional hands-on experience as they treat up to 80-100 refugees a day for various conditions. Afghanistan accounts for the largest refugee population in the world at approximately 3.5 million, Dr. Hood adds.

Because the medics will be practicing much of their medicine in the Afghan countryside — alfresco, as it were — without the luxuries of modern medical facilities or electricity, part of the instruction is done outside as well — under tents or in caves using foot-operated suction pumps, lanterns and open drop ether. While these outdoor techniques do necessitate some mental as well as physical "preparation" by today's modern doctors, a few were able to hark back to their own practical experiences — from days spent as a WWII general surgeon, for example, to a stint as a Vietnam medic.

Perhaps the greatest teaching challenge at this remote med school, however, is the language barrier. Because Dr. Hood doesn't speak the native Dari, a Persian dialect, his lessons must be translated. "Not only do you have to prepare your material and deliver it, you need to have a way of appraising whether the students understand and if the translator is communicating correctly," he explains. "Dialogue is very important," he continues, thus an additional step in teaching must be developed. That is, the students must continually demonstrate their comprehension by *doing.*

Once the training program has ended, the medics set out toward the border in what Dr. Hood describes as "mini-MASH" units — two or three medics with about a ton of medical supplies packed on camel, donkey or horse, containing antibiotics, surgical gear, anesthetics, IV fluids, etc.



Medical techniques, taught by Lancaster orthopedist Henry Hood, MD, are practiced here by Afghanistan medics who will use this information to take care of soldiers wounded in battle.

"The Afghan people capture your heart easily. Almost everyone I know leaves there wishing they could do more or intending to do more."

The medics move along footpaths through mountains which line the Afghan-Pakistan border — some of which are 15,000 to 20,000 feet high and only passable at certain times of the year.

At last count there were about 28 of these MASH units operating inside Afghanistan, and at least one secret unit operating a 10-bed facility in a cave, he says.

The medics log the number of patients and the types of conditions they treat. Taking villagers, soldiers and refugees into account, Dr. Hood estimates the medics see about 30,000 to 35,000 patients per month.

While Afghanistan and its corner of the world is undeniably a volatile region, Dr. Hood doesn't perceive his medical excursions as particularly dangerous. "It's not without risk," he explains, "but there's risk in everything. Walking at night in New York City or driving home after work on a busy freeway — there's relative risk in all these things." Each individual must balance the "relative risk" of any given situation for him or herself. Perhaps it's like Gertrude Stein once surmised: "Considering how dangerous everything is, nothing is very frightening."

Of course, once you take the plunge and get involved in one of these projects, you may find — as the saying goes — that you get as much out of it as you put into it. "The Afghan people capture your heart easily," says Dr. Hood. "They're brave, hospitable, grateful. All this chemistry leaves you with an extremely warm feeling. Almost everyone I know leaves there wishing they could do more or intending to do more." Dr. Hood intends to return early next year.

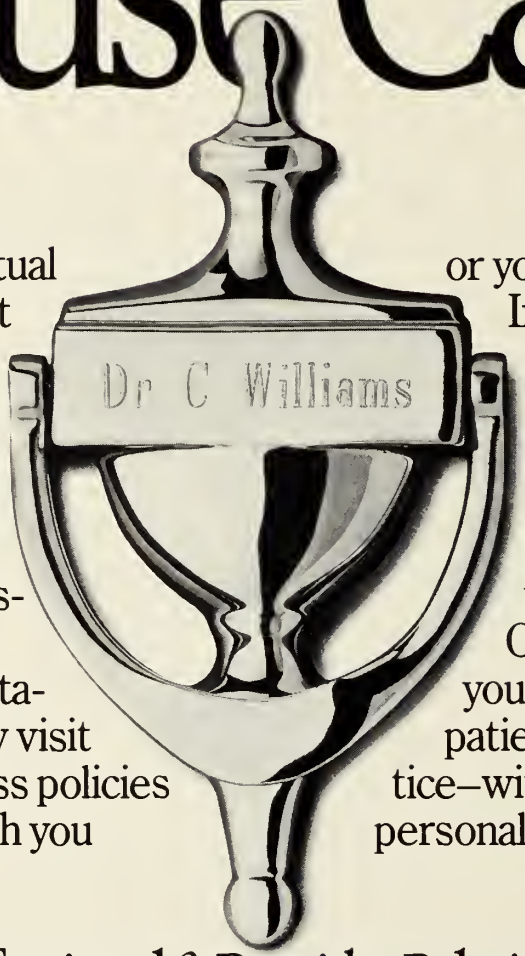
And while it's true that there's much to lament in all of this: the children maimed by Russian "toy bombs," painted to resemble bright butterflies and birds; or the Soviet-made HIND helicopter, which can

continued on page 800

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Luther High, MD

An Open Letter to the Physicians of Ohio

Editor's note: The following "open letter" was written by Luther W. High, MD of Millersburg, Ohio. Dr. High is a long-time, active member of organized medicine, having served as president of the Holmes County Medical Society for 10 years, and as a delegate to the OSMA for 25 years. He was a charter member of the Ohio Academy of Family Practice and served as the first chairman of its scientific committee. In addition, Dr. High was Chairman of OSMA's Public Relations Committee during the time that a publication known as "Your Doctor Reports" was first getting started. The publication eventually evolved into "Synergy."

I have recently been informed by the Ohio State Medical Association that some physicians in active practice and residing in the state are paid-up members of their county medical society but not of the OSMA. Some of these physicians may be members of other societies and therefore owe no dues to our society.

According to the Constitution and By-laws of the county medical societies and OSMA, every county society is a component member of the OSMA and therefore a physician cannot legally be a member of the local society without being a dues-paying member of OSMA.

OSMA dues for the year were $275.00, and for the coming year, 1988, they will only increase to $295.00. This amount is considerably below the average for dues of other states and places the state of Ohio near the bottom of the other 50 states in amount of dues.

Other medical association dues such as the chiropractic and podiatrist organizations are considerably above this figure and labor union dues are still higher, thus enabling those organizations to have greater leverage in getting legislation passed favorable to their organization. OSMA dues have been low because of excellent administration and the high percentage of physicians in Ohio who belong to OSMA. This large membership enables Ohio to have a greater power in the business of running the AMA.

It is very unfair that those who do not maintain membership in OSMA should derive almost the same benefits as do those who do. An example at the local level is the fact that 50% of the cost of the OMEN Program is paid out of Holmes County Society dues, and yet those who do not pay dues of our society are permitted to attend these meetings and obtain credit for licensure.

Too many physicians have little or no knowledge of these benefits and do not realize that OSMA and the AMA are working hard to protect the rights of all physicians, whether they hold membership or not. The programs of OSMA and the AMA are tremendous and there is little question that were it not for organized medicine in the USA, we would probably be practicing a socialistic type of practice today. While we are close to that now, we still have some freedom. Many physicians feel that it is only a matter of time until the government will have complete control over how we practice medicine and that physicians who try to buck the system and remain in private practice will be denied the right to admit patients to a hospital.

While my real concern in writing this letter is to increase membership in the local county medical societies and in OSMA, there are some thoughts that I have held for a long time which I would like to mention.

I am very much concerned about the exorbitant fees being charged by some physicians, and I feel that the care of the ill has become secondary to the desire to accumulate wealth. The Hippocratic oath, which all of us subscribed to, is being relegated to the past and there is too little sympathy for those who, with conditions that are too often beyond their control, are unable to afford medical care for themselves or their family. How often do we forget the expression: "There but

continued on page 803

realize greater profits.

- Patient loses identity and economic control of services.
- Possible delays could exist in referrals.
- Fear of decline of quality of care.
- Fear of being "locked in" to a designated plan physician.

The task force presents for consideration the following recommendations for physicians before contractually entering into a capitated health care system.

Recommendations for Consideration Prior to Participation in a Capitated Health System

- Don't rush to sign up!
- Investigate the reputation and financial viability of the plan, with special emphasis on catastrophic event risk pools.
- Have the contract stipulations reviewed by knowledgeable professionals.
- Physician Know Thyself! Examine your own philosophical and economical ability to accept the contractual requirements.
- Understand your existing market share and potential for change.
- Consult your local medical society or state medical association for additional assistance.
- Attend educational seminars on the subject.

We are hopeful that the report and recommendations of this task force will provide practical insight for OSMA members as they strive to make decisions regarding their participation in various alternative health care delivery systems. The task force wishes to acknowledge its thanks for the dedication and excellent expertise of the OSMA staff — David W. Pennington, William Fry and Janet Shaw in the involvement and preparation of this report.

what's in it for them.

At present, young physicians are faced with a "double whammy," she continues — trying to set up a practice, while trying to wrestle with the by-products of a vastly changing medical environment. "It's difficult to look ahead and make plans when the future is so fuzzy," she says.

"In the past, physicians tended to ignore the politics, the legislation and the finances, and said, 'just let us practice medicine.' But we realize we can't do that anymore. We've got to take the bull by the horn and jump in there." — *Deborah Athy*

The Right Choices . . .

continued

you want to get involved. You can make a difference."

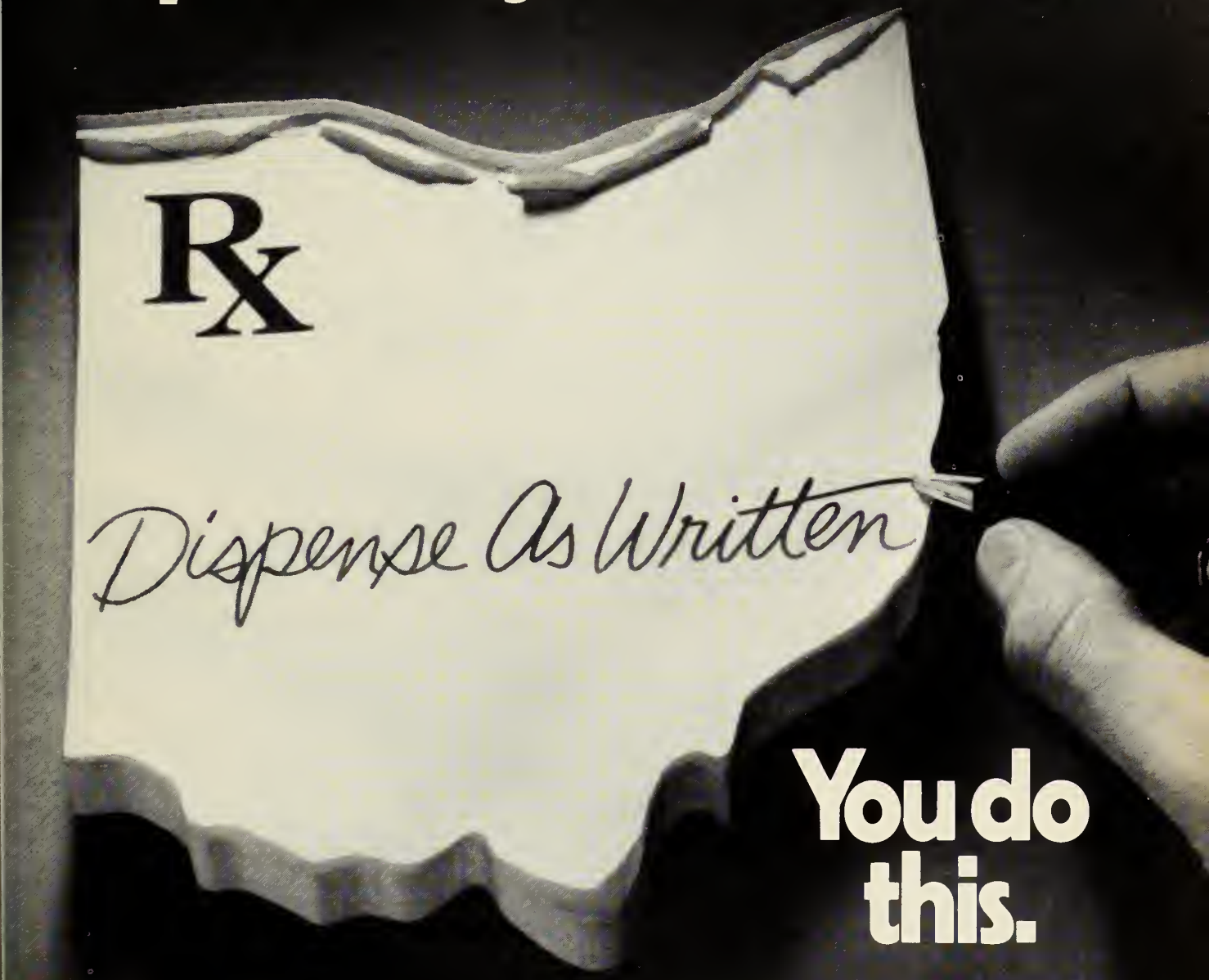
While more young physicians are showing up at OSMA/AMA functions, Dr. Trippe, a newly-appointed member of the OSMA Young Physicians Committee, says some young physicians may be disenchanted with reorganized medicine. But he looks at participation in medical associations a little differently. "Organized medicine may not allow me to change the world," he says, "but I can change a little corner of it." — *Deborah Athy*

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— MD, Southern Ohio

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A. The "hold harmless" on "fair fee support" programs are indeed becoming more of an issue with OSMA physician members. In 1987, the OSMA House of Delegates adopted resolution 20-87 which calls for the OSMA to identify the extent of this "hold harmless" activity in Ohio, and, if indicated, the Council is instructed to review legal steps available to challenge these programs. Currently, the OSMA is seeking examples of this activity in order to evaluate the extent of its usage, and also opinions of physicians affected by the programs. Please send examples to: OSMA Ombudsman, 600 S. High Street, Columbus, Ohio 43215.

Eleven Miles . . . *continued*

devastate a village in 60 seconds . . . all hope is not lost.

The Russian government has indicated in recent weeks that it plans to withdraw troops and gradually disengage from the war — but this remains to be seen.

Despite the fact that Afghanistan is the underdog as far as sheer power and might, "the people are adamant about their resistance, which represents the feelings of 90% of the people in the country," Dr. Hood says.

"They're proud of their heritage and their independence. They've got incredible odds against them, but they have always resisted any domination, by the British, Genghis Khan, Alexander the Great. They have a clear picture of their freedom." **OSMA**

Deborah Athy is Associate Editor of **Ohio Medicine.**

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Otitis media due to *S pneumoniae, Haemophilus influenzae,* staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis,* and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Reversible interstitial nephritis has been reported rarely. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

PV2211 DPP

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Additional information available to the profession on request from

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by the grace of God, go I''? I well realize that the cost of office and medical supplies and the cost of malpractice insurance etc. have greatly increased our expenses, but I often think of how difficult it is for the low wage earner to give his or her loved ones adequate medical care and wonder if there are not more times when we should be compassionate to those unfortunate in a great many localities. Physicians do realize this and are staffing clinics that make no charges for those unable to pay.

Years ago, we treated all who needed care regardless of their ability to pay. In many instances we were well repaid simply by the expression of thanks shown by those people — the cost to us was simply considered a cost of doing business.

Let us never forget that the truly needy patient who is on welfare is also a human being and should be treated accordingly. None of us like the welfare system as it is being run today, but let us never forget that many are on welfare through no fault of their own, and that they love members of their family just as much as we do and want them to enjoy good health.

I am concerned about the failure of too many physicians to participate in community affairs. Too few of us belong to service or charitable organizations and if we do belong, we frequently take no part in the work they do. I have been on the Board of Trustees of my local county Red Cross and have participated in their fund drive each year for many years. I am ashamed of the amount contributed by local physicians to this world-wide organization, whose administrative costs are some of the lowest of any organization, when every one of us has benefited as have our patients financially from the free use of Red Cross blood. Have you ever stopped to think what would happen in the world if every volunteer who serves in such an organization would suddenly stop doing volunteer work?

It is my fervent hope that those physicians who have not paid their dues to their county medical society and to OSMA would do so before the end of the year and join in 1987.

We are a privileged group, a group which has been fortunate to have parents who believed in education and helped us to reach the plateau where we stand today. We are privileged to have wives and families who, although they have had to give up many things as a family, have been able to have most of the finer things in life. We are privileged to have a station in life in which we are looked up to as leading members of society and in our communities; privileged to alleviate suffering and sickness in our fellow man; privileged to have an income which is at or near the top of all professions and which lets us enjoy many of the things in life denied to many; and privileged to send our children to college and to help them become established as adults. I ask each of you: Do we not owe something to our profession by belonging to an organization such as our medical societies and philanthropy organizations to protect that which has given so much to us as individuals and to those who will follow us in our profession?

There is little time left for us to stop the avalanche of changes in the delivery of health care which most of us think are not for the best, and which is already well on its way. If you care enough to help to stop this avalanche join the OSMA, write to your governmental representatives at the state and national level and express to them your suggestions and fears which will enable this nation to pass legislation that will continue to make the type of medical care provided in the USA the best in the world and at an affordable price.

Luther W. High, MD

surgical opinions, out-patient surgery, pre-admission certification and other schemes, are not even adequately staffed to make a qualified medical-surgical decision. When a physician actually has the audacity to question their opinion, they don't answer their telephone or mail! Furthermore, in some cases, the decision maker is not even licensed to practice medicine in Ohio — which is what they are attempting to do when they try to alter patient care. It is clear to me that instead of lowering or controlling the cost of medical care, these new programs only redistribute the cost — to the health planner, the health-care reviewer and to the third parties themselves.

In my opinion, the cancer of the third party intervention will continue to grow and spread its poison throughout our present health-care delivery system unless we the participants arm ourselves with an adequate antidote. I would like to suggest that this antidote appears to be the acquisition of the facts and knowledge to intelligently, but forceably say ''no'' to any further mandates affecting our patients' access to quality care and their freedom of choice of physician.

As I recall, a lot of tea was once dumped in the Boston harbor to point out the basic American principle of freedom of choice and freedom of enterprise. Are we, the patients and physicians of America, worse citizens than our forebearers? That question, physicians of Ohio, must be the focus and lead point of all of our endeavors to ensure an American solution to the above problems.

D. Ross Irons, MD, President of the OSMA, practices surgery in Bellevue.

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BOARD-CERTIFIED ANESTHESIOLOGIST
Northeastern Ohio teaching hospital with an approved, four-year residency program in anesthesiology seeks a board-certified anesthesiologist with extensive interest and experience in academic setting. Responsibilities will include research, teaching and clinical practice. Excellent salary and benefits leading to early partnership. Send curriculum vitae and reference to: John G. Poulos, MD, Chairman, Department of Anesthesiology, Huron Hospital, 13951 Terrace Road, Cleveland, OH 44112.

CARDIOLOGIST. Excellent opportunity for Board-Certified with invasive/non-invasive skills. Hospital and Office practice in North Central Ohio. Reply to Box 154, c/o OHIO Medicine, 600 South High Street, Columbus, OH 43215.

CARDIOLOGIST — Looking for a ground-floor opportunity to establish an independent practice? Fully equipped and staffed medical space in Cincinnati is seeking to add a cardiologist to a growing internal medicine and rheumatology group practice. We provide all in exchange for future consideration based on your ability to build your private practice. Future Healthcare is a privately held company specializing in conducting clinical research for the pharmaceutical industry. Our physicians and staff collaborated on over 40 separate trials during the past year, and anticipate the need to associate with a cardiologist interested in clinical research in arrhythmias, hypertension, and congestive heart failure. If you are a physician committed to medical excellence, have an interest in research, a desire for independence, and want the upside financial rewards of your hard work, then this is the opportunity for you. Please send your CV, in confidence, to Gary M. Pekoe, Ph.D., Future Healthcare, Inc., 455 Delta Avenue, Suite 306, Cincinnati, OH 45226, or call (513) 321-2525.

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EMERGENCY MEDICINE EDUCATION COORDINATOR — Immediate opening for full-time position at a 500-bed community hospital with 32,000 visits annually. The applicant should have completed a residency in Emergency Medicine or possess ABEM certification. Responsibilities include clinical supervision of Emergency Medicine, General Surgical, Family Practice residents. Participation in Trauma Service, Emergency Medicine Residency development, Occupational Health Program and EMS training programs desirable. Fairview General is a progressive Level 1 facility located in affluent Cleveland Westside suburbs, one-half hour from Lake Erie. Remuneration is $120k yearly. Submit CVs to: Joseph J. Badal, MD, FACEP, Chairman, Department of Emergency Medicine, Fairview General Hospital, 18101 Lorain Avenue, Cleveland, OH 44111, (216) 476-7312.

EVANSVILLE, INDIANA. Immediate position available for board-certified family practitioner in busy, growing network of ambulatory care centers. Excellent income. Flexible scheduling. Contact MEC Medical Centers, 3844 First Ave., Evansville, IN 47710. Attn: Rebecca Parker, (812) 428-6161.

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FAMILY PRACTICE — Opportunity to join a group practice in family and/or internal medicine. Currently have six locations in Greater Cincinnati area. Excellent benefits and productivity incentives. Stay one year or make it a career. Call (513) 651-5546 for application or send CV to: Physician Care, Inc., 617 Vine Street, Suite 1320, Cincinnati, OH 45202.

FAMILY PRACTITIONER (BE/BC). Excellent primary care opportunity with expanding hospital-sponsored physician group. Southwest Ohio location. Progressive philosophy, comprehensive salary and benefit package. Send CV to Reply Box 159, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215.

FULL/PART-TIME IMMEDIATE CARE PHYSICIANS — Multispecialty group seeks physicians for its Ambulatory Care facilities. Expansion of satellites within the greater Cleveland area offers excellent opportunity with outstanding salary, bonus incentives and full membership potential. Send CV to: Kevin L. Trangle, MD, MEDNET/Euclid Clinic Foundation, 18599 Lake Shore Blvd., Euclid, OH 44119.

GENERAL PHYSICIAN AND PSYCHIATRIC positions available in Ohio, full or part time. Private practice opportunities are optional. Contact (216) 449-2662.

HEALTH CARE PERSONNEL CONSULTING, INC., A DIVISION OF THE HEALTH CARE GROUP, specializes in valuation and sales. We have practices currently available in the following specialty areas: **Allergy, Dermatology, Family Practice, Internal Medicine, Ophthalmology, Pediatrics, Psychiatry, Psychology, Radiology and Urgent Care.** For more information regarding selling or buying a medical practice, contact our brokerage division at The Health Care Group, 400 GSB Bldg., Bala Cynwyd, PA 19004 or call (215) 667-8630.

HOUSE PHYSICIAN — Full- and part-time Medical/Surgical House Physician positions available immediately. Ohio license is required. Prefer Board eligible/certified physician. Hospital is in a community setting. Attractive salary and benefits. Contact Parma Community General Hospital, c/o Medical Staff Services, 7007 Powers Boulevard, Parma, OH 44129.

HOUSE PHYSICIANS. Full- and part-time positions. Must have a minimum of 2 years residency either in Internal Medicine, Surgery or Family Practice. Current ACLS certification and Ohio license is required. Call collect or submit resume to: Personnel Dept., St. Francis-St. George Hospital, 3131 Queen City Avenue, Cincinnati, OH 45238, 513-389-5260.

IMMEDIATE POSITION AVAILABLE — Multispecialty Northeast Ohio Group seeking BC/BE primary care physicians: Family Practice, Internal Medicine, Pediatrics and OB/GYN. Guaranteed salary with opportunity for ownership. Excellent benefits. Reply to: *OHIO Medicine,* Box 135, 600 South High Street, Columbus, OH 43215.

INTERNIST (BE/BC WITH OR WITHOUT SUBSPECIALTY) to join rapidly expanding hospital-sponsored primary care physician group. Southwest Ohio location. Progressive philosophy, comprehensive salary and benefit package. Send CV to Reply Box 158, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215.

MARIETTA, OHIO — Emergency Department directorship and staff position available at 200-bed facility. Board certification or Board eligibility in Emergency Medicine or primary specialty preferred. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; or call 1-800-253-1795, in Michigan 1-800-632-3496.

MEDICAL DIRECTOR for First Urgent Care Center, Parma, Ohio. Board eligible, competitive starting salary with percentage of profits. Send your C.V. to Ray Fuentes, Administrator First Urgent Care, 5515 Broadview Rd., Cleveland, OH 44134 or phone (216) 749-2622.

OBERLIN, OHIO. 20-person multispecialty group seeks additional BC/BE family physicians, internist, OB/Gyn, otolaryngologist and general surgeon. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

AIM HIGH

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OB-GYN PHYSICIAN
Opportunity available to physician in our community. Firelands Community Hospital is a new 273 bed facility located midway between Toledo and Cleveland on Lake Erie. Primary service area population is 80,000.* Send CV to: Firelands Community Hospital, 1101 Decatur Street, Sandusky, OH 44870 or call (419) 626-7721. (*All support services available)

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Needed now to work with a unique, internationally respected rural health system network in Kentucky which includes a hospital, satellite clinics, a home health agency and a school of advanced nursing. A regional medical center is within 20 miles. The practice environment is stimulating – physicians and Advanced Registered Nurse Practitioners work in joint practice teams; interaction with students is encouraged; the rural population presents a wide range and intensity of medical problems.

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OCCUPATIONAL MEDICINE TRAINING. Mini-Residency beginning June 6-17, 1988 and continuing October 10-14, 1988 and March 20-24, 1989. Clinical & Administrative Occupational Medicine, Epidemiology & Biostatistics, Industrial Hygiene, Toxicology, Regulations, etc. 111 AMA Cat I, AAFP prescribed, Cat 2-D AOA and Cat I participants provided. $675 per week. Sidney Lerner, MD, College of Medicine, Mail Location 182, Cincinnati, OH 45267-0182, (513) 872-4043.

OHIO: BC/BE pediatrician to replace retiring senior member in active, progressive five-member pediatric group near Cincinnati and Dayton. Competitive salary, fringes and practice situation leading to early partnership. Excellent community. Reply Box 156, c/o OHIO Medicine, 600 South High Street, Columbus, OH 43215.

OHIO, CLEVELAND. Emergency Department Physician. 316-bed community hospital. Emergency Department sees 19,000-20,000 visits per year. Resident training in EM/FP/IM/GS or Board-Certified/Eligible in a primary medical specialty required. Starting salary $100-$110K. For more information, contact Mitchell Leventhal, MD, at (216) 642-1400, or send CV, in confidence, to 6133 Rockside Road, Suite 10, Independence, OH 44131.

OHIO, CLEVELAND. Urgent Care Centers. Full and part-time positions available for Board-Certified/Eligible — FP/GP/EM/Peds/Surg/IM physicians interested in providing quality patient care. Annual compensation $75,000-$80,000, plus revenue sharing and additional benefits. For more information contact Mitchell W. Leventhal, MD, at (216) 642-1440, or send CV, in confidence, to 6133 Rockside Road, Suite 10, Independence, OH 44131.

OHIO, NORTHEAST — Immediate full-time emergency medicine opportunity available. Modern ED with moderate patient volume. Competitive rates, flexible scheduling and malpractice insurance provided. Benefit package available. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OTOLARYNGOLOGIST — BOARD CERTIFIED or eligible. Needed to begin practice immediately in Southwestern Ohio. Private practice, 16 years, well-established with metropolitan area serving over 350,000+ for General Otolaryngology, Facial Plastic Surgery, and Allergy. Near many well-equipped hospitals. Contact S. Johnson, (513) 435-0422.

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HELP! NEEDED: Used or new medical equipment, surgical equipment, X-ray equipment, office equipment, and medical supplies of all types; lab equipment; hospital beds, etc. etc. All donations are TAX DEDUCTIBLE. Items to be sent to Haiti to be used by Lifeline Christian Mission, a Columbus, Ohio-based non-profit organization. Items will supply small 36-bed hospital/clinic to enable it to provide long-needed quality medical care to the diseased, malnourished, impoverished Haitian people. Contact Gretchen DeVoe, Lifeline phone (614) 882-8900 or write c/o PO Box 24176, Columbus, OH 43224. Thank you!

Miscellaneous

WRIST WATCHES WANTED: Will either buy or donate to your favorite charity the value of your old doctor's wrist watch. Send watches to: Dr. Nekrosius, 5300 Far Hills Avenue, Kettering, OH 45429.

Position Wanted

BOARD CERTIFIED CARDIOLOGIST (internist) Invasive-Non Invasive, Ohio licensed, wishes to join group, hospital, industry, company, etc. Reply to Box 125, c/o *OHIO Medicine,* 600 S. High St., Columbus, OH 43215.

Practice for Sale

ORTHOPEDIC AND DISABILITY Evaluation Practice for Sale. Northeast Ohio, population 60,000. Sale includes orthopedic facilities, dictaphones, transcribers and copy machine. Excellent hospital facilities. Will introduce. Please send reply to OHIO Medicine, Box 130, 600 S. High Street, Columbus, OH 43215.

ORTHOPEDIC PRACTICE FOR SALE: Southwestern Ohio, population of 50,000. Easy access to two metropolitan areas. Sale includes orthopedic facilities (X-ray, etc.). Income may gross over $200,000. Large number of follow-up industrial cases. Box 130, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215.

PRACTICE FOR SALE: Excellent opportunity for MD to take over retiring physician's general practice. Office building, records and equipment available. Contact: HERENDEEN CLINIC, 203 N. Main St., New Lexington, OH 43764. Phone (614) 342-2533.

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OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

First District
Stanley J. Lucas, MD
2905 Burnet Avenue
Cincinnati, Ohio 45219
Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren

Second District
William J. Marshall, MD
2600 Far Hills Avenue
Dayton, Ohio 45419
Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby

Third District
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Lima, Ohio 45801
Allen, Auglaize, Crawford, Hancock, Hardin, Logan, Marion, Mercer, Seneca, Van Wert, and Wyandot

Fourth District
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2743 W. Central Avenue
Toledo, Ohio 43606
Defiance, Fulton, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Williams, and Wood

Fifth District
Henry G. Krueger, MD
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North Olmstead, Ohio 44070
Ashtabula, Cuyahoga, Geauga, and Lake

Sixth District
J. James Anderson, MD
5204 Mahoning Ave., Suite 103
Youngstown, Ohio 44515
Columbiana, Mahoning, Stark, and Trumbull

Seventh District
Nermin D. Lavapies, MD
1220 Hughes Avenue
Martins Ferry, Ohio 43935
Belmont, Carroll, Coshocton, Harrison, Jefferson, Monroe and Tuscarawas

Eighth District
John F. Kroner, Jr., MD
Box 708
Athens, Ohio 45701
Athens, Fairfield, Guernsey, Licking, Morgan, Muskingum, Noble, Perry, and Washington

Ninth District
Thomas P. Price, Jr., MD
Holzer Medical Clinic
385 Jackson Pike
Gallipolis, Ohio 45631
Gallia, Hocking, Jackson, Lawrence, Meigs, Pike, Scioto, and Vinton

Tenth District
H. William Porterfield, MD
3650 Olentangy River Rd.
Columbus, Ohio 43214
Delaware, Fayette, Franklin, Knox, Madison, Morrow, Pickaway, Ross, and Union

Eleventh District
Charles G. Adams, MD
5896 Liberty Avenue
Vermilion, Ohio 44089
Ashland, Erie, Holmes, Huron, Lorain, Medina, Richland, and Wayne

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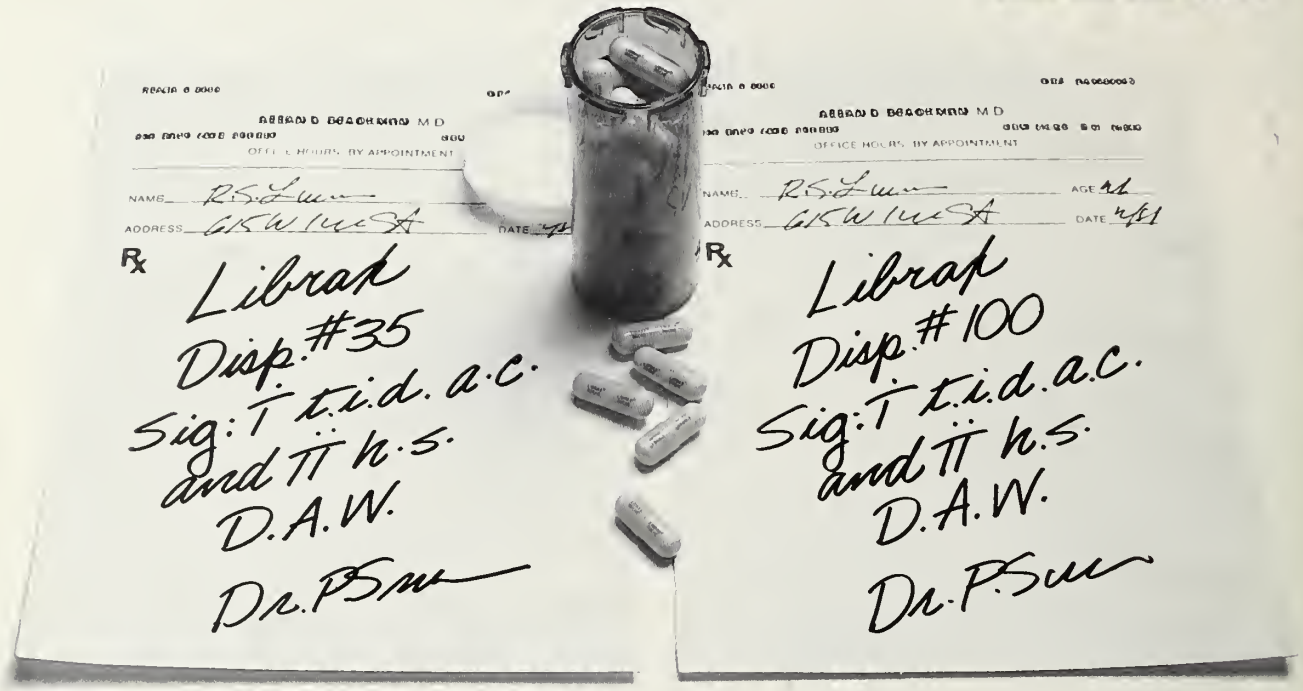
*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and the irritable bowel syndrome.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

PI 0186

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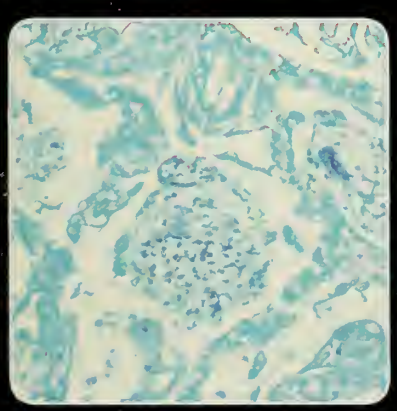
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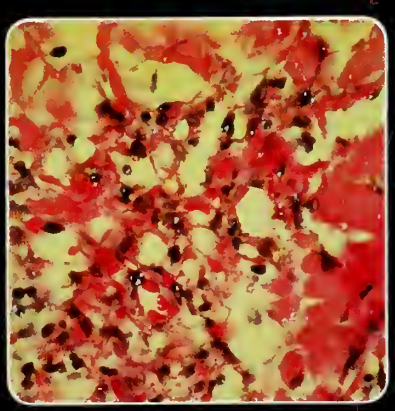
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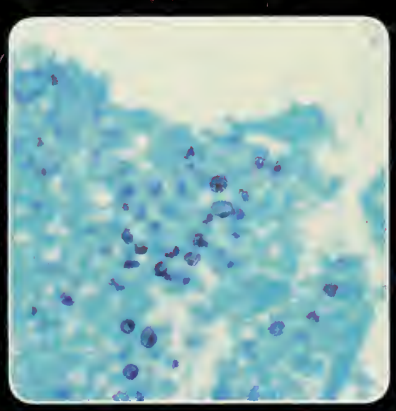
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AIDS UPDATE

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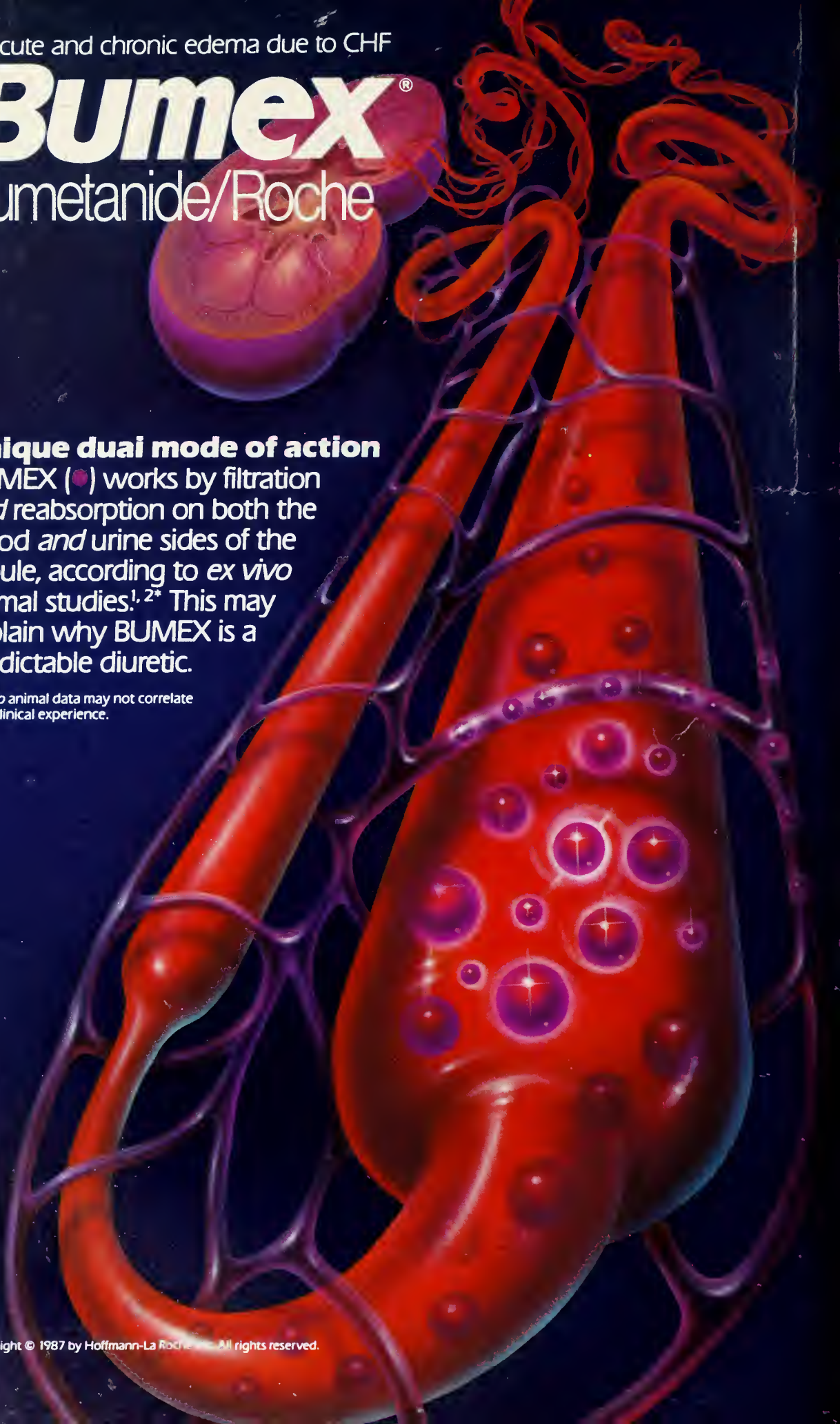
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Less potassium loss for a given amount of sodium excretion than with furosemide.[3-5] As with all loop diuretics, excessive doses of BUMEX can lead to profound diuresis with water and electrolyte depletion, including hypokalemia, so serum electrolytes should be monitored.

More predictable GI absorption—85% with BUMEX and 40%-60% with branded furosemide.[7] The unpredictable absorption rate of furosemide may cause uncertainty about the amount of drug needed.

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Please see following page for references and summary of product information.

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0.5-mg, 1-mg and 2-mg scored tablets; 2-ml ampuls and 2-ml, 4-ml and 10-ml vials (0.25 mg/ml)

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WARNING: Bumex (bumetanide/Roche) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dosage schedule have to be adjusted to the individual patient's needs. (See under DOSAGE AND ADMINISTRATION in complete product information.)

INDICATIONS AND USAGE: Edema associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome
Almost equal diuretic response occurs after oral and parenteral administration of Bumex. If impaired gastrointestinal absorption is suspected or oral administration is not practical, Bumex should be given by the intramuscular or intravenous route
Successful treatment with Bumex following instances of allergic reactions to furosemide suggests a lack of cross-sensitivity
CONTRAINDICATIONS: Anuria. Hypersensitivity and in patients in hepatic coma or in states of severe electrolyte depletion. Although Bumex can be used to induce diuresis in renal insufficiency, any marked increase in blood urea nitrogen or creatinine, or the development of oliguria during therapy of patients with progressive renal disease, is an indication for discontinuation of treatment
WARNINGS: Dose should be adjusted to patient's needs. Excessive doses or too frequent administration can lead to profound water loss, electrolyte depletion, dehydration, reduction in blood volume and circulatory collapse with the possibility of vascular thrombosis and embolism, particularly in elderly patients
Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risks to the patients
In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients
In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses
Patients allergic to sulfonamides may show hypersensitivity to Bumex
PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets
Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion
Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes
Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions
Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions
Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously
Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics
Probenecid should not be administered concurrently with Bumex
Concurrent therapy with indomethacin not recommended
Bumex may potentiate the effects of antihypertensive drugs, necessitating reduction in dosage
Interaction studies in humans have shown no effect on digoxin blood levels
Interaction studies in humans have shown Bumex to have no effect on warfarin metabolism or on plasma prothrombin activity
Pregnancy: Bumex should be given to a pregnant woman only if the potential benefit justifies the potential risk to the fetus
Bumetanide may be excreted in breast milk
Pediatric Use: Safety and effectiveness below age 18 not established
ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease)
Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting
Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, asterixis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection
Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO_2 content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy
Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts. Increases in urinary glucose and urinary protein have also been seen
DOSAGE AND ADMINISTRATION:
Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose
Parenteral Administration: Administer to patients (IV or IM) with GI absorption problem or who cannot take oral. The usual initial dose is 0.5 to 1 mg given over 1 to 2 minutes. If insufficient response, a second or third dose may be given at 2 to 3 hour intervals up to a maximum of 10 mg a day
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PI 1085

FROM THE EDITOR

A Clinical Treasure Trove

This issue of OHIO Medicine is full of articles based on the "Clinical Update" meeting held this past September in Columbus. "Clinical Update" was the OSMA's first attempt to separate the scientific meetings from the business meeting of OSMA's House of Delegates which is held each spring.

According to Gail Dodson, Director of OSMA's Department of Administrative and Educational Services and chief coordinator of both events, the split seemed to work out well. Approximately 350 physicians from all over the state turned up to attend seminars on a wide variety of subjects, ranging from AIDS to hypertension (and that doesn't include the several specialty groups which held their Annual Meeting in conjunction with the Clinical Meeting). "It was a different crowd from the one we used to get when the scientific sessions followed the House," she says — which must indicate that a brand-new group of members are taking advantage of the benefits of belonging to the OSMA.

And that brings up another article you'll find in this issue — a reminder from the Membership Department that it is, once again, time to pay your dues. In case you're wondering (or have forgotten) just what your dues dollar covers, the "Focus on Membership" column will help

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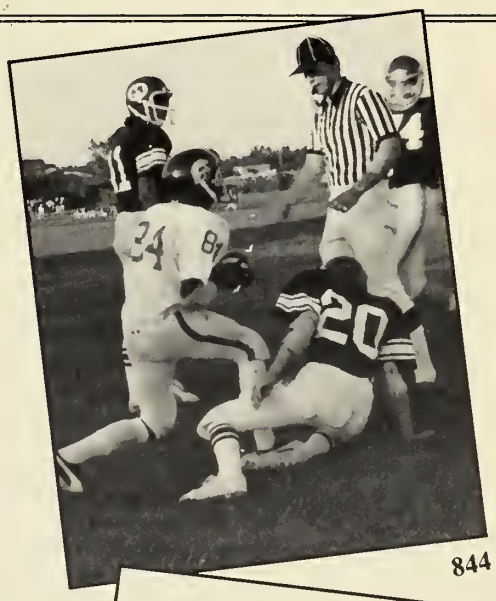
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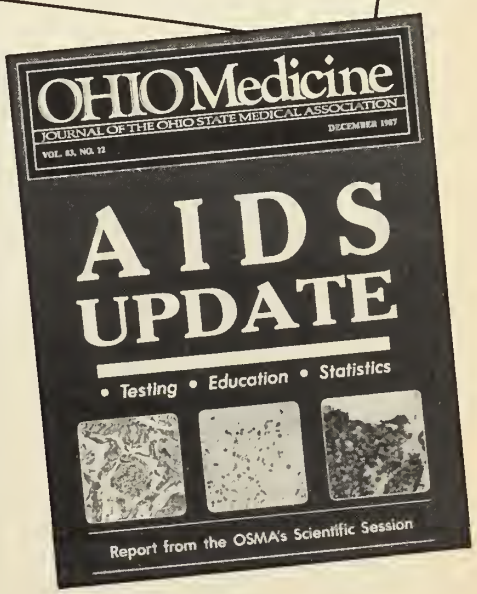
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Published monthly under the direction of The Council for and by members of OHIO Medicine, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1987 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: OHIO Medicine, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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From the Editor . . . *continued*

remind you of the benefits of membership. (And if you want a real nuts-and-bolts breakdown, check out the annual audit which can also be found in this issue.)

Our "Specialty Update" section sidesteps the specialties this month so that a recurring "Technology Update" column could be run. We think you'll find the article on "Non-surgical Use of the Laser" to be especially enlightening — it was written by the Father of Laser Medicine himself — Leon Goldman, MD.

Another article you shouldn't miss can be found in our "Ohio Medi-scene" section. Associate editor Deborah Athy informs you about the new Smoking Policy which is being initiated at OSMA headquarters in Columbus. And following *that* thought . . . you might want to catch the "Medi-scene" article on the OSMA Cancer Committee, recently reactivated by President D. Ross Irons, MD. The Committee, and its Task Force on Breast Cancer Screening, are already off to a very active start.

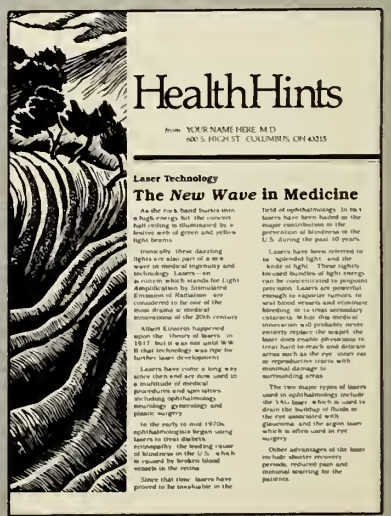
Finally, everyone on the staff of OHIO Medicine, as well as the entire staff of the OSMA, extends to you our warmest holiday greetings. And may next year's issues bring you only good news . . .

Karen S. Edwards

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What's Right in Medicine?

By D. Ross Irons, MD

As we enter this festive holiday season, I would ask your leave for a moment to focus on the positive aspects of the year. Those of you who know me know I am not one to view the world through rose-colored glasses, but I think this review is long overdue. In the ongoing — and often frustrating — battle to protect our rights and the rights of our patients, it is easy to overlook those things that are "right" about medicine. One of those things is your membership in the Ohio State Medical Association.

So, although this issue of *OHIO Medicine* may reach you before the traditional "Twelve Days of Christmas," and with the reminder that eight maids a' milking are hard to come by these days, I would like to present to each of you twelve "gifts" from the OSMA.

1. **Assistance with third-party payors.**

The OSMA Ombudsman service is available to all members who need assistance in untangling the red tape of reimbursement. The Ombudsman is very knowledgeable regarding the ins and outs of reimbursement — with all of the various payors. The Ombudsman can usually walk you through most of the problems that may arise.

2. **Representation in the State Legislature.**

As the government becomes increasingly involved in health care, we must fight back or risk losing everything we have fought so hard to win. In Ohio, approximately 10% of the 2,000 bills that are introduced in the State Legislature each session impact health care. Some of these bills are good public policy, many are not. Without the OSMA's involvement, the legislature would have no way of knowing what effect the bills would have on health care in this state. Furthermore, the answer to many of the problems facing us as physicians can be resolved through the state legislature. A good example is the successful tort reform legislation which the OSMA initiated earlier this year. As physicians many times we like to bury our heads in the sand and "just practice medicine." The problem is, you just can't do that anymore.

3. **Communications with your patients and the public.**

The OSMA takes very seriously its job of communicating *for* you to your patients and the public. In the office setting it is difficult and time-consuming for you to explain to patients your concerns about the changing medical environment. It is even more difficult for you to get this message to the public. Yet, without this information, when something "bad" happens in medicine, people tend to blame doctors. To reach the public, the OSMA regularly issues news releases on timely issues and responds to requests for information from the media. To help you communicate in the office setting, the OSMA is publishing a series of free brochures on socio-economic topics, such as professional liability and Medicare, which are designed to be distributed in the waiting room.

4. **Legal advice and assistance.**

I know that as physicians we all enjoy a good lawyer joke. I am even told that, on occasion, lawyers enjoy a good doctor joke. But is is naive to think that we can operate these days without the advice and counsel of a good lawyer. The OSMA monitors legal proceedings in the state regarding medicine, and takes part in those proceedings when action is called for. A good example is our involvement in *Hardy vs. VerMeulen,* the case the Ohio Supreme Court recently handed down which held that the statute

continued on page 818



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WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin[ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

***Supplied:* 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

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LETTERS TO THE EDITOR

Student-to-Student

To the Editor:

I read the article in the September issue of *OHIO Medicine* entitled "Medical student teachers." Your article distorted several facts. Let me tell you the real story.

In March of last year, my wife, Eileen Voigt, a fourth-grade teacher at Whitehouse Elementary, asked me (not Steinman) if it would be possible for her to bring the fourth-grade class to our anatomy lab to see human hearts. I told her that the policy of MCO did not allow non-health professionals into anatomy lab, but I would see if I could bring some hearts and some anatomical models to the fourth-grade classes. I then went to Dr. Morse, who was the director of our anatomy lab, and inquired about that possibility. Through the help of MCO's anatomy department I obtained "normal" hearts and some hearts that had obvious signs of disease. I enlisted the help of three fellow classmates: James Porter Jr., Peter Shershen and Lyle Calcamuggio. We gave the presentation to Whitehouse school. It did go over real well. The students loved it, as well as the teachers. However, Steinman was not there and could not have recalled an event he was not present for. The four of us also loved doing the presentation.

I decided that it would probably be of benefit to other medical students and the local school children to have a program where medical students could go out in the community and present topics using actual tissue specimens. I discussed this with my wife, Eileen. She agreed and used her experience as an educator to help me select topics students and teachers would find of benefit. Those topics were: heart, lung, brain, dangers of drugs and alcohol, smoking and how to become a physician. I then approached the Student Affairs Office of MCO with the idea of establishing a student organization at MCO to give these presentations. My idea was to target all of the schools within a one hour drive of MCO. I asked only for permission to use MCO's name. I was willing to pay for the postage to mail the information to the schools. While we were waiting for my request to go through the channels at MCO, James Porter had procured another school for us to talk to. We decided that the four of us would go again since we did not have permission to use MCO's name, and would have found it difficult to get other students involved without that permission. That presentation was also well received. Afterward, the student affairs office told me that we could use MCO's name, but not for advertising purposes. We would have to depend on using word of mouth. Later that day Mr. Steinman also went to student affairs and discussed with them a speaker's bureau that the OSMA student section wanted to start. They suggested he talk to me. The OSMA's idea was to get a group of students together to go give talks to community service organizations. I told him of what we had been doing, and what we wanted to do and he thought that maybe the OSMA would sponsor us and thus solve our problem of not being able to advertise. I agreed. No communication occurred between myself and Mr. Steinman over the summer, but once school started again I asked him what had become of his offer. He told me that it was being considered. I provided him the list of all schools within an hour of MCO. The wheels of bureaucracy turned slowly. Almost one year after the first presentation in Whitehouse, Mr. Steinman came to me with a sample of the advertisement to be sent to the schools. However, the ad was only addressed to high schools. I explained to him that the real challenge (and likely most of our requests) would be from the elementary schools. I also recommended some changes on the forms. While this was going on, the four of us who did that first presentation were still out in the community giving presentations. We even gave two presentations to the staff of an Army Reserve Hospital. We solicited the help of another student for one of them. Finally, the OSMA got the information to the schools, and we started getting requests.

As long as I am writing this letter, I am going to also provide my opinion on how the program is being handled now that the OSMA has taken it over. It is nice that the students going out to the schools are provided with information on the subject they are going to discuss, but it is information they should already know. It would be of more benefit for the students to go to the schools armed with their knowledge and just pass along that knowledge to the students. I think a "lessons learned" log could be kept to help future lectures, but I am strongly opposed to the more or less canned briefing format that the OSMA has adopted for Student-to-Student. We are going to be delivering health care, and an important part of that health care is being able to communicate and relate to the patient. My idea was to have a vehicle to practice doing that with basic science knowledge, where the medical student would be responsible for integrating and presenting the material in a understandable fashion. I am afraid that under the program the way it has evolved now, all that is being offered the medical student is the opportunity to practice public speaking.

continued on next page

Letters to the Editor . . . *continued*

I apologize for the length of this letter, but when so many errors are made in an article, it takes a little more explanation to correct them. If you doubt my account, I am sure you can contact the principal at Whitehouse. He will be able to confirm most of this account.
David W. Voigt
Toledo

PRO clarification

To the Editor:

In regard to the July article, "The Peer Review Process: New Focus, New Directions . . ." and the statement that ". . . Congress passed the Professional Standards Review Organizations (PSROs) Act . . .," it is more correct to note that PSROs were part of the Social Security Amendments of 1972, that when enacted on October 30, 1972, became Public Law (P.L.) 92-603. The bill itself, which included other provisions for Medicare and Medicaid beneficiaries, was reintroduced to the 92nd Congress as H.R. 1 on January 25, 1972.
Sincerely,
Leonard J. Janchar, MD
former Chief, Medical Services Branch
Division of Medical Care Standards
Community Health Service DHEW
Marion

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STATEMENT OF OWNERSHIP MANAGEMENT AND CIRCULATION

1A. TITLE OF PUBLICATION: Journal of the Ohio State OHIO Medicine Medical Association	1B. PUBLICATION NO: 0 0 3 0 1 1 2 4
2. DATE OF FILING: 10-23-87	
3. FREQUENCY OF ISSUE: monthly	3A. NO. OF ISSUES PUBLISHED ANNUALLY: 12
3B. ANNUAL SUBSCRIPTION PRICE: $15.00	
4. COMPLETE MAILING ADDRESS OF KNOWN OFFICE OF PUBLICATION (Street, City, County, State and ZIP+4 Code) (Not printers): 600 S. High Street, Columbus, Ohio 43215-5680 Franklin County	
5. COMPLETE MAILING ADDRESS OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHER (Not printer): 600 S. High Street, Columbus, OH 43215	
6. FULL NAMES AND COMPLETE MAILING ADDRESS OF PUBLISHER, EDITOR, AND MANAGING EDITOR (This item MUST NOT be blank)	
PUBLISHER (Name and Complete Mailing Address): The Ohio State Medical Association, 600 South High Street, Columbus, OH 43215	
EDITOR (Name and Complete Mailing Address): Karen S. Edwards, 600 S. High Street, Columbus, Ohio 43215	
MANAGING EDITOR (Name and Complete Mailing Address): none	

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FULL NAME	COMPLETE MAILING ADDRESS
Ohio State Medical Association (a not-for-profit, with no stock outstanding)	600 S. High Street Columbus, OH 43215

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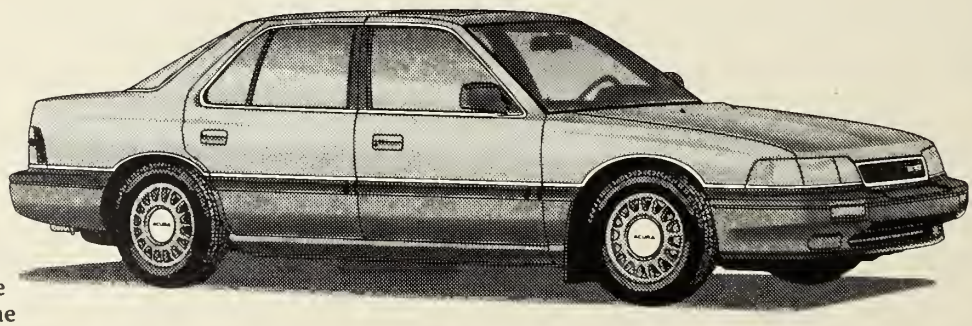
10. EXTENT AND NATURE OF CIRCULATION (See instructions on reverse side)	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NO. COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
A. TOTAL NO. COPIES (Net Press Run)	20,402	20,225
B. PAID AND/OR REQUESTED CIRCULATION 1. Sales through dealers and carriers, street vendors and counter sales	--	--
2. Mail Subscription (Paid and/or requested)	19,715	19,525
C. TOTAL PAID AND/OR REQUESTED CIRCULATION (Sum of 10B1 and 10B2)	19,715	19,525
D. FREE DISTRIBUTION BY MAIL, CARRIER OR OTHER MEANS SAMPLES, COMPLIMENTARY, AND OTHER FREE COPIES	437	450
E. TOTAL DISTRIBUTION (Sum of C and D)	--	
F. COPIES NOT DISTRIBUTED 1. Office use, left over, unaccounted, spoiled after printing	250	250
2. Return from News Agents	--	--
G. TOTAL (Sum of E, F1 and 2 - should equal net press run shown in A)	20,402	20,225

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Antibiosis: Triumph Over Cancer

By L.B. Greentree, MD

Cancer never will be conquered as long as scientists continue to ignore a simple biological fact: namely, that life on earth reflects interaction between living microorganisms (antibiosis), with microbes playing a major role in causing and curing human disease. It is hypothesized that microbe interaction will give rise to clinical-appearing cancer in a step-by-step fashion usually over a period of years.

It is also predicted that antitumor antibiotics will triumph over cancer, just as the microorganism penicillin and other antibiotics revolutionized the treatment of infectious disease roughly 40 years ago. The clinical importance of antitumor antibiotics is emphasized by the fact that, without any visible evidence of previous extensive investigative research, three antitumor antibiotics were included in the eight most profitable cancer chemotherapy agents for the American Pharmaceutical Industry during the year 1983. One of them, Adriamycin, was the most profitable anticancer agent at that time. The other two were Bleomycin and Mitomycin.

The recent emphasis on conquering cancer at the molecular level appears, for all matter of purpose, an unsolvable problem, with no prospect of a cure in the foreseeable future. Conversely, the recent experience with antitumor antibiotics from a profit viewpoint clearly provides attractive evidence that these particular antibiotics are the right route to take to win the final battle against this dread disease.

The following observations in the news media and *The Lancet* (London) put the urgency of the topic at hand into proper perspective:

The Lancet (London), 2, 1000, Oct. 31, 1981: Between June, 1978 and October, 1980, the Advisory Committee on Cancer Registration, whose first report appeared in 1970, reconvened under the chairmanship of professor E.D. Acheson. Being, in the main, statistical rather than clinical oncologists, Acheson and his colleagues do not evade the uncomfortable truth: "With a few exceptions where there have been dramatic results, principally involving rare types of cancer, the results of treatment as measured by survival are generally little better than they were 20 years ago."

The New York Times, Feb. 4, 1986: Whatever role the mind may play on the onset and progress of cancer, a few hard facts seem to stand out. One is that "the war on cancer" in the last quarter century (except for leukemia, Hodgkins disease and a few other forms) seems to have been a losing campaign; cancer mortality actually increased to 185.1 deaths per 100,000 Americans in 1982 from 170.2 per 100,000 in 1962. Dr. John Cairns of Harvard University's School of Public Health, among other experts, contends that there have been no significant gains against cancer since the 1950's despite all the new diagnostic techniques, therapies, lists of carcinogens and positive-thinking nostrums.

Considering that the documented, successful landing of men on the moon necessitated the expenditure of great sums of money in only a few years to accomplish this feat, it is proposed that the United States once again use this costly approach with antitumor antibiotics hoping to win the final battle against human cancer. **OSMA**

Leonard B. Greentree, MD, is a retired physician living in Columbus.

of repose regarding malpractice suits was unconstitutional. The OSMA hopes to have a positive impact on the final outcome of this crucial case by appealing it to the U.S. Supreme Court.

5. **Monitoring of the administrative rule-making process.**

In addition to our legislative activities we also are very involved in the administrative rule-making process. Today, many groups who can't get what they want legislatively often opt to go through the administrative rule-making process. A good example is the many allied health-care practitioners who try to expand their scope of practice by changing the administrative rules. The OSMA closely monitors this rule-making process and intervenes when problems may occur.

6. **Liaison with health-related groups and agencies.**

Medicine doesn't operate in a vacuum in this state and, for this reason, it is important that we maintain close contact with all entities which impact health care. The OSMA works closely with state agencies such as the Ohio Department of Health and the Ohio Department of Human Services, with health care associations such as the Ohio Hospital Association, and with various insurance groups. This close association helps us identify common areas of concern and resolve problems quickly when they arise.

7. **Liaison between the component county medical societies.**

The OSMA works closely with the county medical societies. A field service representative, the District Councilors and the OSMA staff frequently attend county medical society meetings both to inform the membership on issues of interest and to learn from the meetings the problems faced by local physicians. The OSMA places a high priority on working with the county medical societies since this relationship is vital in order to preserve our goal of being a part of a federation of doctors.

8. **Liaison with state specialty societies.**

Now more than ever it is vital for all of organized medicine to work together instead of splintering into separate groups. To help coordinate the activities of the many state specialty societies, the OSMA offers administrative, public relations and lobbying assistance to these groups. These activities help us focus on common goals.

9. **Patient relations and marketing assistance.**

Physician marketing has become a buzzword in medicine, but, for many of us, it boils down to good patient relations. The OSMA recognized this in 1984 when it became the first state medical society to offer members marketing assistance. Today, that tradition is continued in the various marketing tools which are offered by the association.

10. **Affiliation with Physicians Insurance Company of Ohio.**

The OSMA maintains a close working relationship with the Physicians Insurance Company of Ohio. PICO was formed in 1976 to provide Ohio physicians with much needed professional liability insurance. Today, PICO offers a much wider range of products, but the goal is the same: to provide Ohio physicians with the insurance they need. Members of the OSMA are eligible for group rate on PICO's malpractice insurance.

11. **A wide range of membership products.**

The OSMA constantly upgrades and evaluates the services it offers its members to make certain they are meeting member needs. These programs, car leasing, insurance programs, credit cards, are an important benefit of membership in the OSMA.

12. **Participation in a statewide federation.**

I've saved the best for last. Your participation in the OSMA makes you part of a statewide federation of physicians and gives you the opportunity to speak out for medicine. Each year at the OSMA Annual Meeting, elected representatives make the policy that governs this association. Sometimes it may seem that we are a voice in the wilderness. But I remind you that this voice can be heard when the message is truthful and of benefit to mankind.

It is my sincere hope that you will use the above "gifts" and, with the strength and inspiration normally gained through family, friends, and church during the holiday season, that you will resolve this new year to be more determined than ever to preserve the best health-care system in the world.

Furthermore, since it has long been recognized that the best gifts bless both the giver and the receiver, I hope this message will inspire you to encourage just one non-member of the OSMA to join in our cause. That's a "gift" which will benefit us all.

Finally, I would like to extend a personal holiday greeting from my family to your family. This year my family has been expanded to include not only my wife and children but also the OSMA "family" — officers, council and staff. Together, we look forward with enthusiasm to the challenges of '88. **OSMA**

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

First AIDS hospital fading fast

Mounting debt and an overload of indigent patients has forced American Medical International to announce its plans to close the country's first — and only — AIDS hospital within a year, according to a recent report in *Medical World News.*

The Institute for Immunological Disorders, which is located in Houston, had been in operation only 11 months when the announcement was made in August.

Since it opened, the hospital has lost $8 million, with uncompensated care accounting for $4 million.

According to Ann Wheeler, director of communications for AMI's Houston region, only 30 of the facility's 150 beds were ever readied for use, and the hospital averaged fewer than 15 patients a day. The hospital was unable to attract many private patients because of an agreement with the University of Texas, which barred physicians without university hospital privileges from admitting patients.

Meanwhile, there is talk of another AIDS hospital opening in New York. There, the New York Health Systems Agency has recommended that St. Clare's Hospital, a 250-bed facility in Manhattan, be turned into an AIDS center. Hospital administrators, however, say that converting the hospital would stigmatize patients and staff and increase operating costs.

Liability insurance continues to rise

Data drawn from the AMA's 1986 Socioeconomic Monitoring System (SMS) indicates that the rising cost of professional liability insurance and the rising incidence of claims against physicians continue to pose significant problems for those in the medical field.

The results of the survey show that professional liability insurance premiums averaged $10,500 in 1985. Among obstetricians/gynecologists, the average was $23,300. Since 1982, premiums have increased at an average annual rate of 21.9 percent for all physicians and 28.8 percent for obstetricians/gynecologists.

Among specialty groups, obstetricians/gynecologists were at the highest risk of incurring a claim, followed by surgeons, radiologists and pediatricians.

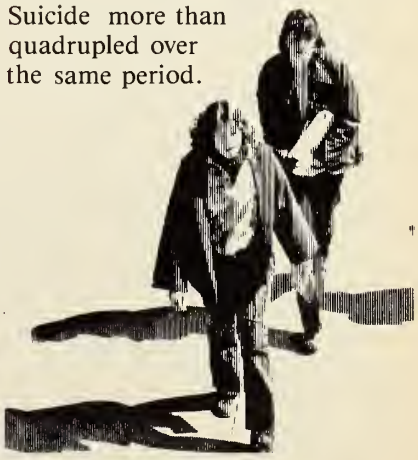
The data also showed that obstetricians/gynecologists paid the highest premiums, on average, in 1985 ($23,300), followed by anesthesiologists ($18,000) and surgeons ($16,600). Radiologists, general and family practitioners, internal medicine physicians and pediatricians paid premiums of $9,100, $6,700, $5,800 and $4,700 respectively. Psychiatrists paid the lowest premiums with an average of $2,600.

Violence is leading killer of youth

Violence has replaced disease as the leading killer of young people in the United States, with adolescents the only segment of the population whose health status has not improved in the past 30 years, says a report in a recent issue of the *Journal of the American Medical Association.*

Accidents, homicide and suicide account for 77% of adolescent deaths in the U.S., writes Robert Blum, MD, of the University of Minnesota, Minneapolis. He reports there has been no reduction in the absolute adolescent mortality rate in the U.S. in the past 30 years; death due to communicable diseases has decreased markedly, but "the rise in violent deaths among adolescents offsets any potential reduction."

Accidents are reported the leading cause of death for children and young adults. Homicide is second, its rate having tripled among youths, age 15 years to 24 years, from 1950 to 1980. Suicide more than quadrupled over the same period.



COLLEAGUES IN THE NEWS

K. WILLIAM KITZMILLER, MD, a Cincinnati dermatologist, has been named the 131st president of the Academy of Medicine of Cincinnati . . . **JAMES PHILLIPS, MD,** Cleveland, has been named associate dean of student affairs and minority programs at Case Western Reserve School of Medicine . . . **JON KROHMER, MD,** Centerville, has received the first Jean Hollister, MD, Memorial Award for Excellence in Emergency Medical Services . . . **JEFFREY C. SEILER, MD,** Gates Mills, has been elected president of the Cleveland Society of Obstetricians and Gynecologists . . . **ROSS R. BLACK II, MD,** Akron, has been elected treasurer of the Ohio Academy of Family Physicians . . . **BERNADINE P. HEALY, MD,** Cleveland, has been named president-elect of the American Heart Association . . . **ERNEST JOHNSON, MD,** Columbus, professor and chairman of the department of physical medicine at Ohio State University Hospitals, has been elected a national vice president of the Muscular Dystrophy Association . . . **EUGENE L. SAENGER, MD,** Cincinnati, was recently honored by the Society of Nuclear Medicine with the 28th Georg Charles de Hevesy Nuclear Medicine Pioneer Award for his work in the field of radiation . . . **GAIL ENGLENDER, MD,** a Cincinnati pediatrician, has been awarded the 1987 Recognition Award by the Cincinnati Pediatric Society. The award is given for distinguished contributions to the health and welfare of children . . . **ANDREW F. ROBBINS JR., MD,** Cincinnati, has been named preceptor of the year by residents in the Family Medicine Department of the University of Cincinnati . . . **TOM D. HALLIDAY, MD,** Marietta, has been elected treasurer of District V of the American College of Obstetricians and Gynecologists . . . **ARNOLD ROSENZWEIG, MD,** a Cleveland oncologist, has been elected president of the Northeast Society of Clinical Oncology . . . **STANLEY GOLDSTEIN, MD,** Youngstown, has been appointed director of pediatric cardiology at St. Elizabeth Hospital Medical Center . . . **GARY L. GILLEN, MD,** Circleville, has been appointed to represent the Ohio Academy of Physicians on the Planning Committee for Regionalization of Child Abuse and Neglect, a new, state-funded, two-year pilot project . . . **WILLIAM J. MARSHALL, MD,** Dayton, has been appointed to the Board of Health of the Combined Health District of Montgomery County . . . **HARRY R. MAXON, MD,** Terrace Park, has been named director of the division of nuclear medicine at the University of Cincinnati Medical Center . . . **JUSTIN G. MILLS, MD,** Xenia, has been elected to the American College of Physicians . . . **PAUL O'BRIEN, MD,** Beavercreek, has been named Director of Trauma Services for Miami Valley Hospital . . . **AUDREY SPENCER, MD,** a Cincinnati family practitioner, has become president of Meadowview Region Hospital's medical staff . . . **BARBARA MURRELL, MD,** McConnellsville, has been named medical director of the Morgan County Drug and Alcohol Council . . . **ELIN KROPP, MD,** Cincinnati, has been named medical director of Llanfair Retirement Community . . . **ROLAND A. GANDY JR., MD,** Toledo, has been elected to the Board of Governors of the American College of Surgeons . . . **THOMAS WERNER, MD,** Finneytown, has been named medical director of Jewish Hospital's department of psychiatry.



William J. Marshall, MD



Roland A. Gandy, Jr., MD

Correction

Due to an oversight, a portion of the story "Medicaid Tips," which ran in the "Ohio Medi-scene" section last month was omitted. The list under the heading: Deletions due to **RECENT FEDERAL (NOT STATE) REGULATIONS** should have included:
Lithonate 300mg; Lithotab 300mg; Lomotil Liquid; Maxitrol 0.0, O.S.; Meclomen 50mg, 100mg; Mellaril 10mg, 15mg, 25mg, 50mg, 100mg, 150mg, 200mg; Metimyd O.S.; Motrin 400mg, 600mg, 800mg; Mycostatin Cream; Mysoline 250mg; Neo-Decadron O.S.; Neosporin 0.0, O.S.; Norpace 100mg, 150mg; Ophthochlor Soln; Optimyd Soln; Pediamycin 200mg/5ml, 400mg/5ml; Percocet; Percodan; Quinaglute 324mg; Regamide O.S.; Regasporin 0.0, O.S.; Regatrol O.S.; Ritalin 5mg, 10mg, 20mg; Robimycin 250mg; Rufen 400mg, 600mg, 800mg; Scabene; Selsun; Septra Susps; Staticin; Stelazine 2mg, 5mg, 10mg; Sulamyd 0.0, O.S. 10%; Symadine 100mg; Symmetrel 100mg; Synalar Oint 0.025%; Tegretol 200mg; Tolinase 100mg, 250mg, 500mg; T-Stat Soln; Vasocon O.S.; Vosol Otic; Vosol HC Otic; Wyamycin E 200mg/5ml, 400mg/5ml; Xylocaine Oint 5%; Zyloprim 300mg.

Correction

Deborah Meesig, MD, a general surgeon with the Central Ohio Surgical Clinic, was incorrectly identified as Debbie Messick, MD on page 758 of the November Journal. *OHIO Medicine* regrets the error.

OHIO MEDI-SCENE

Heart transplants . . . male adolescents . . . OSMA's new smoking policy . . . steroids and heart disease . . . cancer . . . an innovative network for seniors . . . a new name for an old program . . . medical student update

Cutting the red tape around heart transplants



Any medical facility capable of performing open heart surgeries should be allowed to perform heart transplants, according to Christiaan Barnard, MD, the South African surgeon who performed the first human-to-human heart transplant 20 years ago.

Speaking recently at Riverside Hospital's Annual Heart Symposium in Columbus, Dr. Barnard points out, "The heart is the simplest organ in the body. The surgical technique (for a heart transplant) is straightforward, it's easier than replacing valves. There's nothing difficult about it. So who has the right to tell a doctor he can't do a certain treatment?"

Bureaucratic red tape is sometimes needlessly wrapped and entwined around transplant programs across the country, he says. If a medical facility is performing a significant number of open heart surgeries and is adequately staffed to read biopsies and check cyclosporine levels, then CONs, committees and assorted protocols should not stand in the way.

"One has to remember that the evolution of cardiac surgery is dependent on the introduction of new surgical techniques. The heart transplant was an introduction of a new technique. That's all it was, that's how we saw it," Dr. Barnard continues.

But the rest of the world regarded the first heart transplant with a little more reverence. Shortly after the landmark operation at the University of Capetown on December 3, 1967, a media event was in the making, replete with flashbulbs, news cameras and reporters.

In some ways the heart transplant has retained its original touch of elitism in the medical world. But to Dr. Barnard, the beauty of the heart transplant is that, unlike most other palliative heart surgeries, the operation gives a patient a healthy, normal heart. "My philosophy of medicine is quite simple," he points out. "The goal of medicine is not to prolong life. The goal is to improve the quality of life."

The heart transplant operation itself has come a long way. Ensuing years have brought new and improved immunosuppressants, quicker and definitive ways of detecting organ rejection, and more efficient means of storing hearts. In fact, today's surgical units strive for 90% one-year and 80% five-year survival rates for heart transplant patients, he says.

Another boost to the program,

continued on next page

OHIO MEDI-SCENE

Cutting the red tape . . . *continued*

according to Dr. Barnard, has been the debut of the heterotopic heart operation, a.k.a. the piggyback, in which the surgeon makes room for the donor heart next to the patient's own heart. Since Dr. Barnard performed the first piggyback operation in 1973, he has never opted to perform another orthotopic transplant.

"The government must (pay). There is no way the man on the street can afford to pay."

Because organ rejection accounts for 21% of heart transplant failures, the heterotopic method provides a safety valve in case something goes awry with either heart, he says. In addition, more effective immunosuppressants such as cyclosporine also contribute to a curtailed rejection rate.

A persistent thorn in the side of heart transplant programs has been the operation's steep cost, Dr. Barnard admits. But when considering a price tag of approximately $100,000, one also has to consider the alternative — not doing a transplant. If the patient has chronic heart failure and cannot work, the physician must continue to treat him in and out of the hospital, and the system must continue to support him and his family. In these terms, the cost of a heart transplant becomes more palatable, he points out.

"The government must be responsible for the cost or should contribute part of the cost for high tech medical treatment. There is no way the man on the street can afford to pay," he says.

Another problem is a lack of donor hearts, Dr. Barnard continues. Mechanical hearts have not really been developed to the extent that they can be used as permanent replacements, so they are best suited as temporary bridging devices, he says. The wave of the future, according to Dr. Barnard, will be xenographs — using animal hearts for transplants, including goats, calves, hogs, baboons, etc. — which he predicts will be attempted sometime this year. However, he points out that animals should not be killed for the sole purpose of procuring organs.



Christiaan Barnard, MD, pioneered heart transplants.

Wrapping up his presentation, he left the audience with a message — one he hopes will catch on with the public as well: "Don't take your organs to heaven. Heaven knows, we need them here." — *Deborah Athy*

The group that health care forgot

They claim the country's highest mortality rate — in terms of number of homicides, suicides and motor vehicle accidents — and have an equally alarming rate of drug and alcohol abuse. Yet, according to Paul Williams, MD, a pediatrician at Cleveland Metropolitan General Hospital, these same individuals are those most likely to be forgotten, even ignored, by our nation's health-care system.

The group that Dr. Williams has targeted is that of male adolescents.

Dr. Williams was in Columbus to address the topic, "Adolescent Males: Youth Forgotten by the Health-Care System," during the Ohio Department of Health's Third Statewide Adolescent Health Conference held in September.

While Dr. Williams admits he is alarmed by teen-age male death statistics — the male rate is almost three times higher than the female rate — he says his interest in adolescent male health care peaked when he began noticing differences in the way male and female teen-age patients are treated in the office and clinical setting.

"The girls who would come in would get all sorts of counseling," he says, while "the boys were getting short-shrifted."

He notes that this trend is especially prevalent in VD and

family-planning clinics. Because complications from sexually-transmitted diseases are relatively rare in males, they usually receive little or no counseling, he says.

To make his point, Dr. Williams notes a study in which teen-agers were tested for gonorrhea. Males who tested positively were treated and told to come back for follow-up treatment. Females who tested positively were also treated and told to return for follow-up treatment. Females who missed their next appointment, however, received a reminder letter *and* a phone call. Males were not contacted again at all.

"We're failing somebody somewhere and we need to do something about it," Dr. Williams says.

Similarly, the teen-age male is frequently ignored when his girlfriend becomes pregnant, Dr. Williams says. At some clinics and hospitals, the father of the child is not even identified, he adds.

"What *about* the fathers?" asks Dr. Williams. "They're really on the receiving end of a lot of negativity. They're always blamed . . . the myth is that the boy makes the baby and then disappears."

As the teen-age girl's pregnancy progresses, the teen-age father is even more likely to be ignored, which may lead to alienation on the male's part and resentment toward his girlfriend and child.

"It's a major problem and the guys feel that," Dr. Williams says. "They don't feel welcome in the clinics, for the well-baby checks."

Dr. Williams says that, in his own practice, "If I ever see them (the fathers), I make it a point to talk to him, to try to get him to come back."

Dr. Williams offers two theories as to why teen-age males do not seek or receive the health care they deserve. The first, he says, concerns society itself.

"It has something to do with the way we're all socialized," he says. "Males have always been taught not to complain, to keep this in. Don't tell anyone you're sick. Be macho."

The second theory relates to teen-agers' sense of invincibility.

"You have all these kids with all the physical capabilities of an adult and a 12-year-old's mentality," Dr. Williams says. "They think, 'It won't happen to me . . . If I can't see it, I can't understand it.' The ability to abstract doesn't happen until late adolescence."

What physicians and health-care workers need to do, he says, is guide their young patients and *ask* questions.

"If you can kind of shepherd them through this time — until their psychological capabilities catch up with their physical ones — then maybe you can help." But, he adds, "You have to have the discussions, you have to ask the questions and you have to talk to them." — *Michelle Carlson*

"We're failing somebody somewhere and we need to do something about it."



OSMA kicks the habit

Old habits die hard, but the OSMA office in Columbus is determined to break at least one old habit, by launching a new policy which curtails, and eventually forbids smoking inside OSMA headquarters.

The origin of this somewhat controversial concept can be traced to the 1986 OSMA Annual Meeting, in which approved Resolution 35-86 resolved, among other things, "that smoking be prohibited at all meetings sponsored by the OSMA and that proactive non-smoking policies be developed for the OSMA membership and staff."

In answer to the above resolution, OSMA Executive Director Herb Gillen called for the formation of an OSMA Committee on Smoking Policy. The committee, composed of a mix of smokers, non-smokers and ex-smokers, including Donna Allen, Merry Campbell, Robert Clinger, Irene Icenhower, Charlotte Kourie, Susie Paulus and Phyllis Wardell, came up with a comprehensive report and recommendations for smoking at the OSMA.

The committee based some of their conclusions on a smoking survey of the staff which found: 40% of OSMA employees smoke; almost 70% recommend smoking cessation programs; and 75% suggest that there should be designated smoking areas.

In keeping with the OSMA resolution, the committee deemed October 1, 1987 as the first day of smoking prohibitions at the OSMA, with the restrooms, staff lounge, conference rooms, Xerox and storage areas officially declared off-limits for smoking. (A no-smoking rule for the front lobby had previously been implemented.)

The Great OSMA Smokeout got underway November 1, 1987 with smoking limited to stairwells, the westside lobby entrance (High Street), the rear kitchen on the

continued on next page

OHIO MEDI-SCENE

OSMA . . . *continued*

lower level (north), and behind closed doors in private offices.

For those employees who have smoked for many years — or even just a few — the OSMA is offering a voluntary smoking cessation program to help them kick the habit.

On January 1, 1988 the smoking committee will reconvene to review results and make additional recommendations. If all goes as planned, all smoking will be banned, beginning July 1, 1988 — ushering in a new smoke-free era at the OSMA headquarters. — *Deborah Athy*

Steroids may lead to heart disease

A six-month study recently completed by a five-member, Ohio research team shows that unsupervised, excessive use of anabolic steroids can lead to heart disease and a decrease in the body's ability to fight illnesses.

The team studied the diet and physical well-being of 35 body-builders in the first half of 1986. Of the participants, 18 voluntarily took high doses of anabolic steroids, which they obtained on their own, and which they took despite warnings of the drug's potential dangers.

A study of their similar but unsupervised diets revealed that the normal diet involved excessive high fat intake, creating potential for heart disease. Blood tests revealed that the fatty style of nutrition common among the body-builders tended to put the drug users at the greater risk. Dangerously high levels of cholesterol were noted in 44 percent of the steroid users, compared with 24 percent of the drug-free body-builders. Blood tests also revealed evidence that use of the drug significantly suppresses the immune response, lowering the body's ability to fight infection and, possibly, reducing its ability to provide surveillance against the development of malignancy.

Cancer . . . a problem too long ignored?

When D. Ross Irons, MD assumed office as President of the Ohio State Medical Association, one of the goals he outlined for the year was to reactivate the Committee on Cancer, as well as establishing a special task force of the committee which would investigate the "current development of cancer detection centers in the state of Ohio."

"This area seems to be going in all different directions," Dr. Irons told *OHIO Medicine* just prior to taking office. "I want to reinstitute the committee to provide leadership, as well as an arena for developing dialogue on improved treatments. I also want the committee to try to ensure that all entrepreneurial types of cancer centers are under physician direction."



Charles D. Cobau, MD, co-chairman of OSMA's Cancer Committee calls attention to an agenda item. To his left is his co-chairman, Jerome J. Stanislaw, MD, and OSMA President D. Ross Irons, MD.

Although these are awesome responsibilities, the newly-activated Cancer Committee, co-chaired by Charles D. Cobau, MD, Toledo, and Jerome J. Stanislaw, MD, Warren, has already taken steps to address those concerns expressed by Dr. Irons.

A Task Force on Cancer Screening, chaired by John P. Minton, MD, Columbus, has already issued a report, based on its preliminary findings, which Dr. Minton presented to the committee at a meeting in late September.

"The real concern about this topic," Dr. Minton read from the task force report, "lies with the realization that some of these so-called cancer detection centers may be offering the citizens of Ohio a product that they are not adequately trained for or supervised to provide."

The best cancer screening or detection centers, the report continued, continues to be the physician's office — whether physician be an internist, family practitioner, general surgeon, gynecologist, gerentologist or emergency room physician.

"The OSMA should actively promote the concept that every physician's office is a cancer screening center (and) reawaken physicians about their responsibility (in this area)," Dr. Minton read.

In screening for cancer, the task force recommended that certain guidelines be followed — no matter *who* is doing the screening. These guidelines include obtaining:

1. An assessment of the individual family cancer history
2. An assessment of the patient's cancer risk exposures
3. An appropriate historical assessment of bladder, bowel, GI function, swallowing, as well as all areas of concern
4. An adequate exam to include all skin form melanomas, basal and squamous cell cancer and other warning markers

"These are *annual* exam recommendations to be performed by a licensed physician or under the supervision of a licensed and board-certified, practicing physician," the report further specified.

Such guidelines and recommendations as those outlined in the Task Force report *are* important, says Dr. Irons, who was in attendance at that September meeting.

"Physicians have to be prepared with a 'gold standard' as it were, of cancer screening techniques, to provide the basics of what a program should be quality-wise," he says. Besides, once the physician has such a standard list of criteria in place, it is less likely that one will be legislated.

"I see this as a tremendous opportunity for the doctors of Ohio to position themselves into a proactive stance *before* legislation is demanded," he says.

However, both Dr. Irons and Dr. Minton believe that the profession (as well as the public) needs to be educated as to what should be expected in a cancer screening — what are the minimum standards that will be accepted?

If nothing else, Dr. Minton points out, such standards, when publicized, will let the public know when it is being short-changed.

"We don't have to shut down these facilities (cancer detection centers)," says Dr. Minton. "We just want to make sure they are doing an adequate exam and making appropriate referrals."

To enhance this spirit of cooperation, members of the Cancer Committee, along with Dr. Minton, will be meeting with the personnel of several cancer screening clinics from around the state to solidify the "gold standard" for cancer screening.

"We *can* upgrade these programs," says Dr. Irons in agreement.

In related business, the Cancer Committee hopes to:

- Prepare an "office checklist" card which can be attached to patient charts, and which can be ordered, by a physician, in bulk. These cards will serve to remind physicians to screen for cancer by letting them know when the patient was last screened, the results of the tests, etc.
- Develop ways to get educational materials regarding cancer screening into physician offices. "We need to become activists in providing support for these programs," says Dr. Cobau.

In other business, the Committee also decided to:

- Provide information and work with the Cancer Control Consortium.
- Support those communities and businesses which institute a no-smoking policy (the committee applauded OSMA's phased-in "no smoking" policy, which was initiated at OSMA headquarters in Columbus on October 1 — see related story in this section for further details).
- Recommend that treatment possibilities for breast cancer always be discussed with the patient, and that the Ohio Chapter, American College of Surgeons' brochure "Breast Cancer: Diagnosis and Treatment Information" be made available to physicians to hand out to their patients as needed. — *Karen S. Edwards*

The Cancer Committee is an opportunity for Ohio physicians to take a proactive stance before legislation is demanded.

OHIO MEDI-SCENE

"Senior Network" — a first in Midwest

As the population of the United States moves toward that of an aging one — some reports estimate there are currently more than 25.5 million Americans who are over age 65 — more and more health-care facilities are devising ways to meet the special needs of senior citizens.

"There's an increasing number of elderly people in our population," notes Jean Farkas, director of Geriatrics Programs at St. Elizabeth Medical Center in Centerville. "People are living far longer."

As a result of this aging of a population, "hospitals are changing from acute care to chronic, degenerative types of diseases," she says. "As an institution, we'd better know about this population and address those growing needs."

It was precisely this concern — and a merger about a year and a half ago with St. Leonard Center, a local retirement community — that prompted the hospital to adopt the "Senior Network," a system that provides health-care information and services to senior citizens.

"We operate as a link between St. Leonard's and the hospital," Farkas explains. "We see Senior Network as an entry point for all the variety of services we offer in the health-care system."

The Centerville program is currently one of only four operating in the country, and the first in the Midwest. Two others are located in California, and a fourth is located in Oklahoma.



Introduced in August, the Centerville program offers members health-related information, health screenings, doctor referrals, even help processing insurance claim forms.

"Our feeling is that people often don't know where to go to get help, so we're offering ourselves as a source of information," says Farkas. "It's a way of helping people access the complicated health-care services."

Together, the two centers purchased the network plan from Age Way, a company owned by Dr. Ken Dychtwald, a leading authority on aging. The program's initial introduction in August was followed shortly by a direct mailing of a brochure, which listed a number to phone for information.

So far, says Farkas, the response has been tremendous. "We get calls all the time. We've had close to 7,000 people respond to it (the brochure), so we've had a really heavy response."

The network, however, is by no means complete, as a resource center is scheduled to open in late November. The center, which Farkas describes as "a library of resource material aimed at older people," will offer books, pamphlets, audiovisual materials and magazines that focus on the health and lifestyles of senior citizens. Once the center opens, network members will be able to borrow materials at their leisure or have staff members compile information on specific subjects. Home delivery of materials will also be arranged for those who are unable to get to the center.

While the program is aimed primarily at the elderly — membership is free and open to those 55 and over — Farkas predicts a diversified clientele once the resource center opens.

"We feel strongly that we should be supportive of families and the resource center will be especially useful for families with elderly relatives," she says. — *Michelle J. Carlson*

Healthchek — a new name for an enduring program

Since 1974, physicians have been providing preventive health screening for children of Ohio Medicaid recipients under a program known as "Early and Periodic Screening Diagnosis and Treatment" (EPSDT). The name has always left something to be desired, say the experts at the Ohio Department of Human Services (ODHS). Put that many initials together, they say, and you find people devising memory joggers — silly phrases — that help them remember which letters come first ("Elvis Presley Song-and-Dance Team" for example). Then, there is the name recognition. Few people associate the initials EPSDT (when they remember them) with the Medicaid program.

So, early this fall, ODHS set out to change all of this. To begin with, they developed a snappy, memorable name for the program — "Healthchek," a clean, neat name that requires no memory joggers and which seems to say it all, without having to spell it out. Now, they are seeking to increase public and professional awareness of the name change — as well as of the program itself.

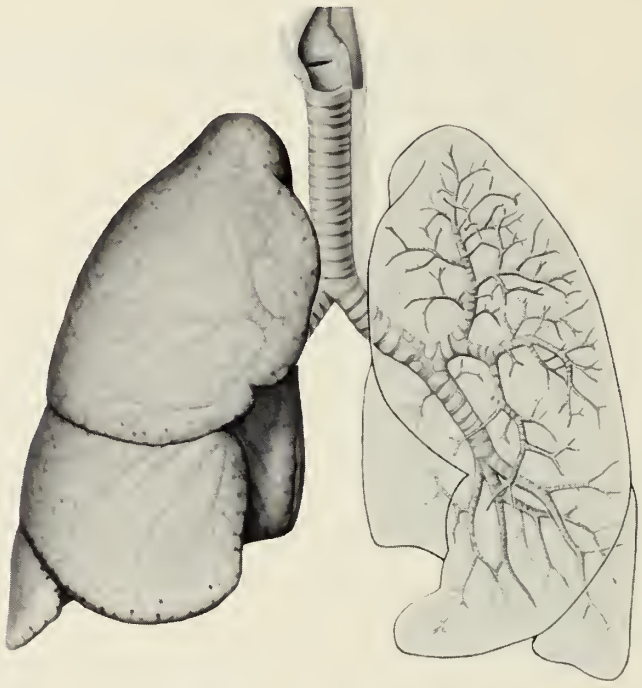
"Healthchek is more complete than the usual child-care exam," explains Morris S. Dixon Jr., MD, Chairman of the Advisory Committee to the Bureau of Medicaid Preventive Health, and a technical adviser to the program since its inception.

Indeed, a Healthchek exam not only checks the child's general health (through a battery of thorough physical exams), but provides necessary shots and examinations for diseases like tuberculosis, anemia and lead poisoning. Six exams are provided in the first year of the child's life — then one exam is provided every year thereafter (this rule, effective as of September 1, 1987 increases the amount of exams given eligible children by one year).

Last year, 1,229 Ohio physicians



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Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

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Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology:
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
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OHIO MEDI-SCENE

Healthchek . . . *continued*

screened 132,000 eligible children — yet the ODHS hopes to increase this number substantially over the next few years.

"It is well-demonstrated that preventive care promotes better health care at lower costs," says Dr. Dixon. "Children enrolled in EPSDT (Healthchek) are less costly to the Medicaid program because once they have a monitored health-care plan in place, they have a tendency to utilize services less."

Yet even with the support of the Ohio Chapter of the American Academy of Pediatrics — whose members served as the program's first advisory committee — the program remains underutilized.

"It's underutilized nationwide," explains Susan B. Schorling, Chief of the Bureau of Medicaid Preventive Health, who adds that, with a 23% participation rate, Ohio is one of the country's better utilizers.

"Ohio has been a leader in this program," she continues. "It is the first and only state to include an initial examination of newborns — apart from the six allowable exams."

And Ohio's program carefully follows the recommendations made by the Ohio Academy of Pediatrics, as well as its Advisory Committee — an achievement of which Dr. Dixon is especially pleased.

Physicians who are interested in learning more about the program, and how they can participate should contact the Healthchek coordinator at their local county Medicaid office or the Ohio Department of Human Services, 30 E. Broad Street, 37th Floor, Columbus, Ohio 43266-0423. (614) 466-4966. — *Karen S. Edwards*

BUREAU OF MEDICAID PREVENTIVE HEALTH MEDICAL ADVISORY COMMITTEE

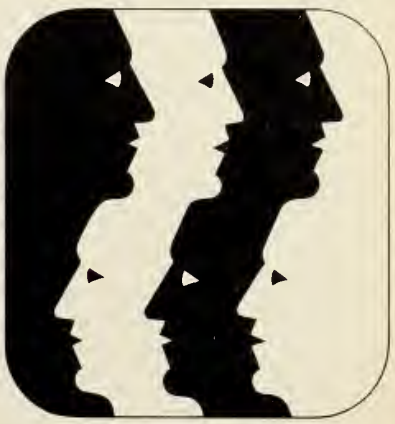
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OSMA-MSS Update

The Ohio State Medical Association Medical Student Section held a very productive governing council meeting on October 18 in Columbus. The membership drive to recruit new student OSMA members is going very well. Ohio State reported that it expects 100% membership in its incoming class of 233.

The student impairment project surveys are expected in by the end of the month and several students from NEOUCOM attended the recent national AMA meeting on impairment.

The OSMA-MSS plans to present a resolution at the AMA-MSS interim meeting concerning the need for medical students to be exposed to people with developmental disabilities. The resolution received strong support from the OSMA-MSS governing council and we hope that it will be well received at the interim meeting. — Cindy J. Smith, Wright State University, year 2





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J-6138 January 1986

CLINICAL
UPDATE

AIDS

The grim statistics . . . and what they reveal

By Karen S. Edwards

Surely one of the most frightening aspects of AIDS are the numbers . . . the stark, cold statistics that reveal victims, positive test results and deaths with the same unemotional comment. In black and white they march off the pages of statistical summaries issued by the Centers for Disease Control (CDC), state health departments and local AIDS Task Forces — growing like fish stories which become more unbelievable with each telling.

And one by one these numbers are being met and treated by the medical profession in hospitals, clinics and doctors' offices — no longer black and white figures on a sheet of paper but real people with faces and names — and the same intense levels of human suffering.

It's easy to report the latest statistics of this dread disease and forget that there are, indeed, real people behind the numbers and neat columns of a monthly report. It's one of the reasons why the figures have become such a frightening part of any discussion which deals with AIDS. The sheer *quantity* of victims and deaths make it almost imperative for those involved with the care of these individuals to indulge in some "psychic numbing." Yet, still, the numbers are tallied. And

still they continue to mount.

"To date, 43,000 cases of AIDS have been reported here in the United States," says Michael Lane, MD, Director of the Center for Preventive Medicine at the CDC in Atlanta, Georgia. Dr. Lane was one of the featured speakers at the Plenary Session on AIDS, presented at the "Clinical Update" meeting of the OSMA, held this past September in Columbus. "But consider," he continues, "that for every case of AIDS, there are four to five cases of ARC," the AIDS-related complex syndrome that appears in some victims prior to the full-blown AIDS virus.

Of course, over fifty percent of those 43,000 cases have occurred in this country's large metropolitan areas — most notably New York, San Francisco, Miami and Los Angeles.

"But make no mistake," warns Dr. Lane, "AIDS is coming to heartland America. Let's not be complacent."

The figures . . . the grim statistics reveal yet another fact.

AIDS is a disease of young people — those who are in their 20s, 30s and 40s where there is usually not much fatal illness. Yet the disease has been listed as the leading cause of death in young males in the San Francisco area, and is claiming more young lives every day in other parts of the country.

Blacks and Hispanics, too, seem to be "overrepresented" in those pages of numbers which are issued monthly and annually in the form of reports. It's not that they are necessarily a higher risk group, explains Dr. Lane, but they are usually "overrepresented when it comes to IV drug use."

"The frequency of the risk group hasn't changed much," agrees Michael Lederman, MD, Assistant Professor of Medicine at Case Western Reserve University's Department of Medicine and co-director of the AIDS program at the University Hospitals of Cleveland. Dr. Lederman also spoke at the "Clinical Update" meeting this past September.

Sexual activity still carries the greatest risk of transmission, he says, and drug users, along with the homosexual population, continue to be the highest risk groups. That's not to say, however, that other groups aren't represented on statistical summaries. For example, heterosexuals who may have been in contact with a member of a high-risk group are beginning to make appearances on tally sheets.

"Women can transmit the disease to men," says Dr. Lederman, explaining that this means a bi-directional, heterosexual spread of the disease is not only possible but likely. "There is potential for an epidemic spread of AIDS," says Dr. Lederman.

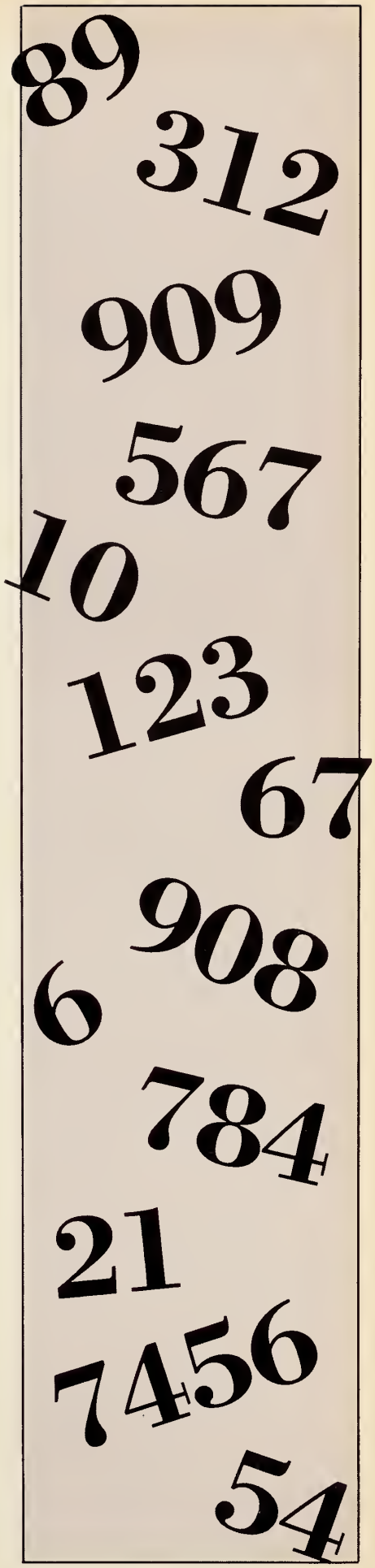
The rate of such a spread is, of course, unknown; however, Dr. Lederman points out that AIDS has spread rapidly in Africa and that the ratio of men to women with AIDS in that country is now one to one (it is presently nine to one in the U.S.).

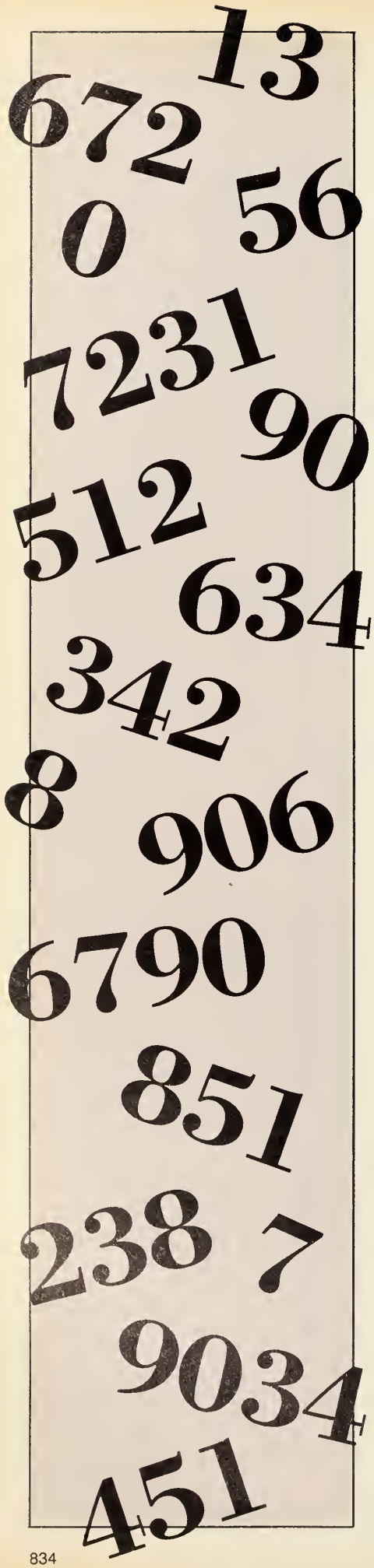
Also appearing now on statistical summaries is the approximately two percent who received the AIDS virus through blood transfusions.

"These are the cases of people who received blood three, four and five years ago. The latency period is coming to an end, though, so we should see no new cases," assures Dr. Lane.

Even small assurances such as this are welcomed in an arena where such comfort is rare. A look at yet another group of victims brings this point home.

"The majority of pediatric AIDS cases we are seeing are, once again, clustered in big-city areas where drug abuse is a problem," says Dr. Lane. In fact, the greatest number of children infected with the AIDS virus are the children of IV drug users and prostitutes who are likely to abandon their infected child — unable, or maybe simply unwilling to take charge of providing the kind of health care their infants need. Most of these children acquired the disease in utero — making diagnosis simple and quick.





The grim statistics . . . *continued*

"The majority are diagnosed at birth," states Dr. Lane.

But life for these newborns is typically short. They die quickly. Only a very small subset will live and go on with their lives — despite the HIV infection they carry.

How long will they — or others — live with the infection? The all-knowing, all-telling statistics come up short in answering this question. No one knows — yet.

"But for every year a person carries the infection, the chances of getting the virus goes up about five percent," says Dr. Lane.

In addition to carrying what amounts to the equivalent of a ticking time-bomb inside of them however, infected persons must deal, also, with the nightmare existence created by public myths and fears.

"There is still a PR problem about the disease," says Dr. Lane. "People still assume that AIDS can be spread casually, that a disease as severe as the AIDS virus must, by its very nature, be highly infectious."

It's a belief that keeps many AIDS patients reluctant to share news of their illness. In some extreme instances, such misunderstandings have even led to violent actions.

"There is no vague method of getting the virus," Dr. Lane emphasizes. "It is spread through direct sexual contact with an infected person, through IV drug use or is transmitted in utero. It is not spread casually."

Dr. Lane says he can make that statement based on several things — one, the number of medical-care professionals who work with AIDS victims but who are not infected; two, the roommates and family members of victims who care for them without becoming infected; and three, the example of a French day care center, where half of the class was composed of hemophiliacs infected with the AIDS virus.

"These children played together with those who were not infected — touching, sharing saliva, bleeding on each other. Yet of the half of the class that was not infected, no child ever got the disease."

Again, a ray of encouragement, but, admittedly, such rays do not occur frequently.

One rather interesting piece of information which is emerging from those monthly statistical reports, however, is that the AIDS virus is beginning to take a few different twists in running its course.

Fewer AIDS patients, for example, are presenting with Kaposi's sarcoma. Kaposi's sarcoma, of course, was the initial tip-off to physicians that a new disease had presented itself.

One rather interesting piece emerging from monthly statistical reports is that AIDS is beginning to take a few different twists.

"Kaposi's sarcoma was, initially, a tumor found in elderly men, usually ones with a Mediterranean background," says Dr. Lederman.

Suddenly, during the early 1980s, coastal city physicians began to see Kaposi's sarcoma appearing in young people. Some of these tumors were small — often mistaken by the patient for an insect bite or a tiny nevi — but the tumor's course was

45 96 50

uncharacteristically rapid — and always fatal.

In what manner is the AIDS virus now appearing, then?

Patients still complain of fever, weight loss and diarrhea. There is still enlargement of the lymph nodes and pneumocystis carinii remains one of the most deadly of the opportunistic infections afflicting AIDS victims.

"Shortness of breath is a hallmark of the disease," says Dr. Lederman. If an AIDS patient complains of shortness of breath, suspect pneumocystis carinii, he urges.

Another new twist the AIDS virus seems to be taking is that, as occurrences of Kaposi's sarcoma decrease, more patients are presenting with neurological and psychiatric symptoms. Of course no one knows, yet, what effect AIDS has on the brain, but researchers are now investigating whether or not certain forms of Alzheimer's or other dementia may develop in those patients who survive with AIDS infections.

Yet no matter *how* AIDS presents itself, one thing is certain — AIDS is an expensive disease — and there are figures to back this up.

Costs for the care of an AIDS patient, for example, can range anywhere from $47,000 a year per patient up to $112,000. And the price tag for AZT, the controversial drug that seems to delay the course of the virus (not cure it) runs anywhere from $7,000 to $10,000 a year per patient.

However, some communities which have a consortium of care in place for AIDS victims are halving the costs of medical care, says Dr. Lane. This "consortium of care" usually means that a social agency in a community has set up hospice or home-care programs for AIDS victims as well as programs which will help victims find housing, and ones which will provide them with meal and shopping services.

"As we learn to take care of AIDS in the community," says Dr. Lane, "perhaps we can learn to do the same with cancer patients and others with life-threatening diseases."

No one will disagree that something, indeed, needs to be done.

"If the trend that is occurring nationwide continues here, Ohio can expect to see 1,500 new cases in the next two to two and a half years," says Dr. Lederman.

Dr. Lane agrees that AIDS will continue to remain one of medicine's biggest problems in the years ahead.

"Even if there are no new transmissions," he says, which he admits doesn't appear very likely, "we can expect to see more patients with AIDS in the next six, seven, eight years — because of the latency period of the virus."

That doesn't mean, of course, that the statistics will bear this out. Currently, figures show that the fatality rate of AIDS is going down.

It's not, of course, says Dr. Lane.

"We have learned to take care of the opportunistic infections that are occurring in AIDS victims, and are recognizing the virus earlier, but there are no true survivors," he says.

And while a search for a vaccination against the AIDS virus continues, both Dr. Lane and Dr. Lederman are skeptical that one will be found in the near future.

"American companies won't produce one because of the liability factor," Dr. Lane points out, adding that there is a practical problem as well. "Who is going to volunteer to test the vaccine?" he asks.

Dr. Lederman agrees.

"So far, an animal model of the disease is not available. And what kind of vaccine would you use? You can't use a whole virus vaccine," he says.

"If the trend that is occurring nationwide continues here, Ohio can expect to see 1,500 new cases in the next two to two and a half years."

Until such problems are worked out by those in the research field, medicine will have to continue with their present treatment strategy, they say — that is, treating the opportunistic infection and trying to reconstitute the patient's immune system while taking whatever steps are necessary to eliminate the HTLV-III virus.

Long-term, however, there are priorities that need to be put into place, says Dr. Lederman.

By educating both the public and the profession about the AIDS virus; mobilizing communities to provide care for its victims; and supporting AIDS research, it's possible, both doctors say, that the grim statistics which parade monthly across reports all over the country will be held at bay until that day when a vaccine or cure can be found. **OSMA**

Karen S. Edwards is Executive Editor of **OHIO Medicine.**

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CLINICAL
UPDATE

AIDS TESTING

By Michelle J. Carlson



Now that a test for AIDS has been perfected, the question remains . . . *who* should be tested?

Since its development in early 1985, the test for antibodies to the AIDS virus has spurred a number of debates in the media, not to mention among members of the medical community and the population in general.

Who should be tested for the AIDS virus? How should the tests be administered? Should results be made available to employers? Insurance companies? Health departments? Who will absorb the enormous costs involved with testing?

The issue becomes no less complicated when one considers the debate raging over mandatory versus voluntary testing. Here, arguments typically run the gamut, with some proponents supporting mandatory testing of all segments of the population, others calling for mandatory testing only of select, high-risk individuals. Still others oppose mandatory testing altogether, preferring instead a system that allows individuals to be tested on a voluntary basis.

Testing for the human immunodeficiency virus (HIV) *can* be beneficial, says Leonard Calabrese, DO, Head Section of Clinical Immunology, the Cleveland Clinic Foundation, but he notes that the physician has an even larger responsibility to his patients. "Our role must be far greater than diagnosing and treating patients," he says, adding that preventive measures — such as educating the public — must take precedence.

As a featured speaker at the OSMA's Plenary Session on AIDS, which was held during the association's annual Scientific Meeting this past September in Columbus, Calabrese sought to dispel some of the myths surrounding AIDS testing and discussed the purpose, accuracy and reliability of such tests.

While there are actually two AIDS tests currently available — the ELISA (Enzyme Linked Immuno-Sorbent Assay) and the Western Blot — many people still do not understand exactly what the tests can and cannot do, Calabrese says.

The ELISA test is widely available and is used as a primary testing tool while the more expensive Western Blot is used to confirm ELISA results. According to Calabrese and literature distributed by the Ohio Department of Health, the ELISA test, which is used to safeguard our nation's blood supply, has a high degree of sensitivity and specificity.

The test, however, is *not* 100 percent reliable, Calabrese warns, and may, in a small number of cases, indicate a false-negative or false-positive test result.

The implications of such uncertainty are twofold, according to Calabrese: A certain number of patients who harbor the virus will be given a false sense of security from testing negatively, while a certain number of otherwise healthy patients will be unnecessarily alarmed by the results of a false-positive test.

It is therefore the physician's duty, Calabrese maintains, to be knowledgeable of the failing of these tests, to accurately interpret their results, to assess the patient's risk group, and to determine if additional testing is necessary.

There are, of course, specific reasons why an individual may be advised to undergo AIDS testing — namely for diagnostic, prognostic, screening or monitor therapy purposes. Of the four, Calabrese notes that most testing is conducted for diagnostic or screening purposes.

For example, if a patient exhibits symptoms commonly associated with AIDS, then he or she may indeed be a candidate for diagnostic AIDS testing, Calabrese says.

Testing done for this purpose can be beneficial, he notes, in that it can make a difference in the quality of patient care and that it can change the patient's prognosis. However, by submitting to such a test, the patient risks losing certain benefits (ie; life and health insurance) if test results are positive and confidentiality is in some way breached.

Another common reason for testing — and the source of much discussion — is for screening purposes. While all blood and organ donors are now routinely screened for AIDS, it has been suggested that testing be applied to other groups as well, including hospital patients, expectant mothers and members of high-risk groups.

While screening in some cases can prove to be a life-saving measure, Calabrese takes exception with including members of high-risk groups in this category because, he says, "It's not effective unless it's combined with counseling." Education, he adds, would probably prove more helpful in stopping the spread of the disease.

continued on page 839

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The downside of testing positively is that the patient may be socially ostracized or risk losing job, home, and insurance.

To illustrate how complex the situation becomes, Calabrese outlines the pros and cons of testing individuals who are considered at high risk for contracting AIDS: If an individual does test positive for AIDS antibodies, the testing has served its purpose in that it identifies an infected person and his or her sexual contacts, thus allowing for follow-up medical treatment as well as counseling. The downside of testing positively, however, is that the patient may be socially ostracized, face extreme psychological duress, or risk losing his or her job, home, and health and life insurance. Calabrese hastens to remind us that there is always the small chance that the patient's test is actually a false-positive, in which case the patient would not actually be infected with the virus.

If a high-risk individual tests negatively, there are similar advantages and disadvantages, Calabrese says. On the one hand, a negative test can give an individual a sense of peace of mind in knowing that he or she has not contracted the deadly disease. On the other hand, the patient may face the same loss of benefits previously mentioned simply by submitting to the test. Additionally, testing negatively does not guarantee that an individual has not contracted the virus, and may in fact instill a false sense of reassurance.

When counseling a patient on whether or not to have an AIDS test, Calabrese suggests the physician remember the following key terms: *respect* for the patient's autonomy and privacy, *harm* (individual liberty versus harm to others), *beneficiance* (how testing will benefit the patient) and *justice* (ensuring that benefits and burdens are evenly distributed).

While no individual can be denied an AIDS test, Calabrese says the medical community has a certain responsibility to counsel and advise patients seeking such tests. Because there is such a negative stigma attached to AIDS, he explains, it is important the patient is aware of all of the consequences before submitting to the test.

In most cases, for example, the test should not be administered simply to satisfy curiosity about the status of one's blood. Rather, Calabrese says, the physician should encourage the patient to take safety precautions when engaging in situations where the virus may be transmitted (ie; by using condoms, not sharing needles, etc.).

Finally, Calabrese encourages physicians to open the lines of communication to their patients. Many physicians, he notes, find it difficult to relay technical information about AIDS to patients in layman's terms, while others may be uncomfortable discussing non-judgmentally a patient's sexual lifestyle. Still others may have little or no experience taking sexual histories from patients.

At the same time, the patient may have doubts about the confidential nature of the office visit and may express reluctance or embarrassment at revealing some of the more intimate details of his or her sexual preferences and habits.

It is up to the physician, Calabrese says, to ensure patient confidentiality and to answer any questions about AIDS as accurately and honestly as possible.

With so much misinformation being disseminated about AIDS, it is imperative that all physicians — from the specialist at a major university hospital to the rural, family practitioner — strive to stay abreast of new information about AIDS, so they can aid their patients in making intelligent decisions where testing is concerned. **OSMA**

Michelle J. Carlson is Editorial Assistant for **OHIO Medicine.**

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AIDS EDUCATION

Keeping the public . . . and the profession . . . informed may be medicine's best (and, presently, the only) way to beat the AIDS virus.

By Deborah Athy

The recent firebombing of a bungalow in Arcadia, Florida — the home of three brothers with hemophilia who tested HIV positive — brings home the fact that AIDS is still widely misunderstood.

"There is a public relations problem with this disease," agrees Michael Lane, MD, Director of the Center of Preventive Medicine at the Centers for Disease Control. For one thing, when genuine news stories about AIDS begin to slack off, tabloid-like accounts about the disease begin to pepper the media.

"Without a vaccine or therapeutic agent, education is our only tool right now," continues Dr. Lane, one of the AIDS speakers at the 1987 OSMA Clinical and Scientific Meeting. Thus messages about AIDS need to be factual, precise and accessible to every cross section of the American public.

Not only does the general public tune into their televisions and delve into their newspapers for information about AIDS, they are probably directing more and more questions to their family physicians. As a primary physician, you should be able to talk intelligently with your patients and give the right answers to questions

"One responsibility of physicians is to reduce fear in the general public . . ."

about transmission modes, treatment, prevention and testing, he says.

"Physicians need to know because they may have to make important decisions about AIDS in the future," says Leonard Calabrese, DO, Head Section of Clinical Immunology at the Cleveland Clinic. One way to stay well-versed about AIDS is by attending AIDS seminars, AMA and OSMA conferences on AIDS, and by keeping up on the latest pertinent literature, he suggests.

In some metropolitan areas, community-based support is doing much to alleviate some of the AIDS dilemma, such as finding housing for AIDS patients, breaking ground for new clinics and circulating information. But in many of the small towns across the country, much of this burden falls on the shoulders of the medical profession.

"One responsibility of physicians is to reduce fear in the general public, to make clear the modes of transmission as well as the ways AIDS is *not* spread," notes Dr. Lane. AIDS is transmitted through direct sexual/perinatal contact and exposure to blood — not by mosquitoes, water, food or casual contact, he reiterates.

AIDS is not a highly contagious disease, as some people — including, perhaps, some of your patients — continue to believe. Dr. Lane points out that health-care workers, family, friends and roommates of AIDS patients have not become infected with the disease through *casual* means, even when in close daily contact.

Those who are in the "danger zone," so to speak, are those individuals who continue to engage in high-risk behavior. "It isn't group membership (prostitutes, drug addicts, homosexuals) that puts one at risk, but the behavior that constitutes the risk for the HIV infection. The risk is what you do, not who you are," according to June Osborn, Dean of the School of Public Health at the University of Michigan and a speaker at the recent AMA conference on AIDS.



State and national experts gathered in Columbus this past autumn to discuss AIDS. Left to right: Michael Lederman, MD; Michael Lane, MD, CDC; Leonard Calabrese, DO.

The message is clear: an individual who engages in high-risk behavior should change his/her behavior to minimize risk. Which means heeding oft-repeated maxims such as "say no to drugs"; sterilize your needles; avoid high-risk sexual practices; use condoms; limit your partners; and practice pregnancy avoidance.

As a physician, these are the kinds of messages you should be giving to your high-risk patients, says Dr. Lane. The first step, however, is to take a complete history of all patients, including information about sexual practices and drug use.

This kind of intimate history-taking may be as difficult for the physician as it is for the patient. Many physicians have little background in this type of history-taking and feel uncomfortable inquiring about such things as sexual preferences. History-taking can also be time-consuming, throwing a glitch in a physician's already-busy schedule.

For the patient, a scrutiny of one's lifestyle can be fraught with embarrassment and fear — not only is the patient's lifestyle being dissected, but he or she may also fear a loss of confidentiality that could ultimately affect job, family, relationships, etc., explains Dr. Calabrese.

Nevertheless, this kind of information-seeking, however precarious, is a crucial ingredient of the total patient care and, in the long run, is in the patient's best interest, he adds.

Physicians should also direct messages about AIDS to those patients who do not practice high-risk behaviors. According to Surgeon General C. Everett Koop, MD, who addressed the AMA AIDS Conference, sexually active adults who are not positively sure whether they or their partners are potential HIV carriers should use condoms.

There are a number of differing views on this contention, including the suggestion that condoms may provide a sense of false security. But as Dr. Koop pointed out, while condoms have never been renown for 100% protection, "short of monogamy or abstinence, they offer the best barrier against transmitting the AIDS virus."

Even in alleged monogamous relationships, there is a shadow of a doubt whether or not a risk for AIDS exists. Citing a recent poll of married women, Dr. Lane

"No physicians should be barred from the practice of medicine solely on the basis of a positive HIV test."

reports that a substantial number could not positively verify if their partners had ever engaged in high-risk activities, such as IV drug use, bisexuality, or sexual relations with a prostitute or someone else considered high risk.

In any case, individuals should resist the temptation to think, *"It can't happen to me — I'm not a homosexual, I'm not a drug user,"* and begin, instead, to incorporate practical, common sense precautions into their lives.

If your patients do begin to ask for information about AIDS, one means to this end is to provide educational literature in your office — a poster tacked to a bulletin board in the examining room, or brochures and newsletters which can be picked up and read. (Watch for ordering information for the OSMA's new patient education brochure about AIDS developed especially for this purpose.)

Because AIDS has no cure, physicians should be prepared to diagnose and treat various AIDS-related illnesses. If warranted, you should be able to refer your patient to the appropriate hospital, specialist or clinic.

Physicians should also be prepared to direct patients to testing centers, or if they plan to do HIV testing themselves, they should implement a concurrent counseling program. Advising someone to get tested for AIDS without following up with counseling is analogous to chiding someone for smoking without providing information about its hazards — the messages lose impact without reinforcement.

While some physicians assume they will never encounter an AIDS patient in their practice, Dr. Calabrese and others advise just the opposite: assume that some of your patients are HIV carriers.

This concept parallels a recent guideline developed by the OSMA Task Force on AIDS which states: "The OSMA advises all persons who come in contact with blood or body fluids . . . of another person to exercise the same precautions as they would if the blood or body fluids were known to be infectious. By assuming this, individuals will incorporate safe handling precautions and measures into their daily routine and significantly reduce their chances of becoming infected."

It goes without saying that physicians and other health-care workers must do everything possible to protect themselves from the possibility of AIDS infection.

Only four cases of positive HIV tests among health-care workers have been reported to date, says Dr. Lane. Whether these individuals belong to any high-risk categories remains unclear.

The observed risk to health-care workers is less than 1%, with prudent practices, he continues. An estimated 37% of all medical mishaps with AIDS can be avoided if health-care workers follow safety precautions.

The most common methods of HIV transmission in a medical environment are scalpel/needle nicks, contamination of open wounds and exposure to blood. Improper scalpel disposal also constitutes another risk.

"No one should ever recap a needle. This is dangerous behavior," cautions Dr. Lane. Physicians should pass this kind of information along to nurses, office personnel, etc.

While there have been no known health professional-to-patient transmissions, "Health-care professionals have a responsibility to know their own status and to take appropriate precautions," says Dr. Lane.

This recommendation echoes another recent OSMA guideline for physicians which reads: "No physicians should be barred from the practice of medicine solely on the basis of a positive HIV test. However, physicians who test positive should protect their patients and their colleagues by using the same procedures for gowning and gloving that they would use if they tested positive for Hepatitis B."

Other individuals have gone out on a limb, in a way, by further suggesting that physicians who test positive to HIV antibodies should avoid invasive surgery — a suggestion which has been met with some criticism.

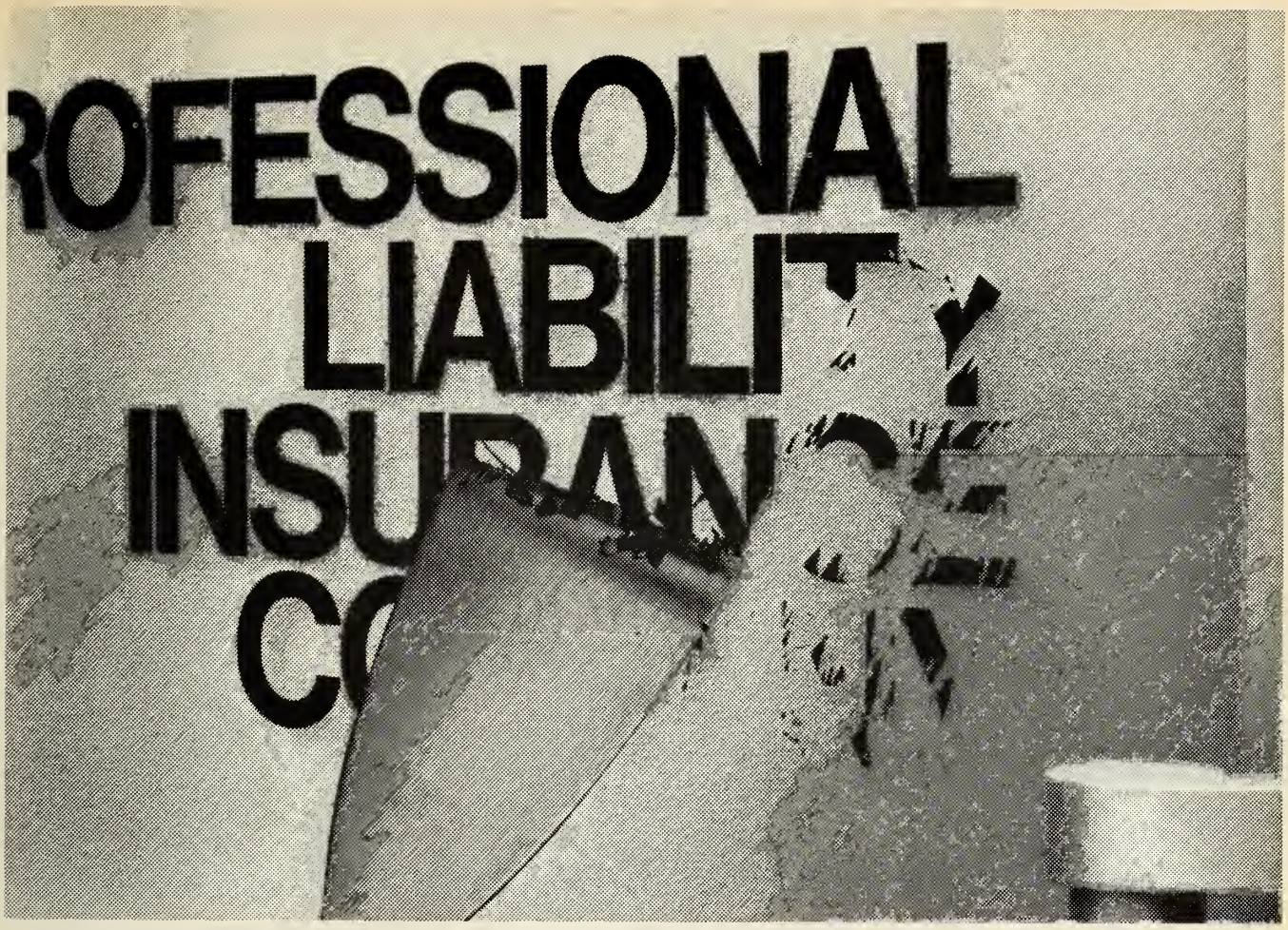
But what *has* been universally agreed upon is that a greater understanding of AIDS among all groups in the country is important — not just to curtail the spread of the disease, but to nip mass hysteria and prejudice in the bud.

And efforts in AIDS education have already begun to pay off in some sectors, according to Dr. Lane. "Sero conversion rates are down in studies of gay men in San Francisco, Pittsburgh, and other cities, as are other types of sexually transmitted diseases."

Self-reported behavior changes also indicate a move in the right direction — condom sales are up, the reported number of sexual partners is down, and there's a greater emphasis on precaution all the way around.

Finally, while there's a long way to go in educating the public, a lot of ground has already been covered. One can only hope that education, what some see as the only tool at present, is soon joined by more curative tools. **OSMA**

Deborah Athy is Associate Editor of **OHIO Medicine.**



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Critical Issues in Sports Medicine

By Michelle J. Carlson

As the number of students active in high school athletics continues to grow — the National Athletic Trainers' Association estimates that nearly 6 million students will participate in organized high school sports this year alone — so, too, do the number of athletic injuries.

And, as the number of injuries rises, more and more private practice physicians can expect to find themselves treating these young athletes both on the sidelines and in their offices.

The fact that two forums — the Ohio Department of Health's Third Statewide Adolescent Health Conference and the OSMA's annual Scientific Meeting — recently addressed sports medicine issues confronting the private physician only points to the fact that it is a growing concern of the medical community.

According to Delphis Richardson, MD, Columbus, one issue at stake for the private physician is the subject of liability. "If you volunteer as a doctor," Dr. Richardson says, "it's almost impossible to be sued." And since few, if any, high schools can afford the luxury of hiring a full-time team physician, it is on a voluntary basis that most physicians serve.

However, warns Craig Barclay, JD, Columbus, if a physician does volunteer his services to a school, he should be aware of the legal ramifications and of his responsibility to the student athletes.

"The liability and responsibility of the team physician (in other than emergency care) is to meet the ordinary standard of care, which is set by your peers," Barclay says. "If you do treat in something you don't know much about, you'll be held responsible for that standard of care as well."

A physician is expected to provide the same high standard of emergency medical care, though Barclay admits there is generally more leeway in such situations. Ohio law essentially says that if a physician voluntarily provides emergency medical treatment, he will not be held liable for damages unless "willful" or "wanton" misconduct on the physician's part can be established — and that, Barclay says, is "pretty hard to prove."

If a physician does find himself on the receiving end of a lawsuit, Barclay notes that he can sometimes defend himself by proving the athlete was in some way negligent (for example, if the athlete played after being warned not to).

However, physicians and lawyers alike agree that the best way to prevent injuries — and lawsuits — is to conduct a standard, pre-

participation exam. The purpose of this exam is to determine whether or not the athlete is suited to his or her sport, to uncover pathology and to quantify the athlete's risk of competing.

Dr. Richardson recommends that physicians take a complete medical history during the exam (including history of illness, injury, orthopedic and congenital defects, mental/emotional problems, etc.), note physical characteristics (height, weight, eyes, cardiac/pulmonary, etc.), order lab tests if necessary, and perform functional capacity testing (neuromuscular, strength, coordination, pulmonary and cardiovascular).

By conducting such a thorough exam, the physician should be able to classify the athlete (unlimited, limited, etc.), set guidelines and offer suggestions for better performance. However, he cautions, "There are very few things that absolutely disqualify an athlete anymore. Adolescents think they're invincible, so if there's a reason they shouldn't play, you have to make sure the parents understand the risks."

Dr. Richardson says that the pre-participation exam is also an excellent opportunity to educate athletes about health and nutrition and offers several pieces of advice:

- The pre-game meal should be large enough to prevent hunger and should include enough water to prevent dehydration. "The meal," he says, "can be any kind of food you want, as long as it is gone by the competition."
- Candy bars and other high-calorie foods should not be eaten for quick energy because it takes a minimum of two to three hours to digest. "The only thing that gives you quick energy is water," Dr. Richardson notes.
- Athletes should not attempt to "bulk up" by eating extra servings of meat and protein. Protein should account for about 13 percent of the athlete's total food intake.
- Not all sweets are unhealthy. "If you're an athlete, sugar is probably very helpful," Dr. Richardson notes, "especially if an athlete is very slim or slender. Then you want refined sugar because it has a lot of calories in a very small package."
- Athletes should avoid using salt tablets. While Dr. Richardson concedes that athletes need extra salt, especially when training in warm weather, he advises that it be added to the regular diet by eating salty foods such as potato chips or pretzels.
- Contrary to popular opinion, milk does not produce excess mucous and should not be withheld if an athlete requests it.

Physicians should be knowledgeable of such fads as blood doping, carbohydrate loading and steroids and be ready to advise.

Dr. Richardson also notes that physicians should be knowledgeable of such fads as blood doping, carbohydrate loading and steroids, and be prepared to advise young athletes of hidden risks.

Blood doping, which involves drawing off a pint of blood, training at a high altitude for a month, and then returning the blood to the body, is used by some athletes to build up red blood cell mass. However, he notes, the practice is rarely, if ever, seen at the high school level.

Carbohydrate loading, which involves depleting the body's source of carbohydrates and then loading up on them shortly before a competition, can be helpful for endurance athletes, Dr. Richardson says, "but for high school athletes, there's not much you can use it for. It's not hurting anything, but I don't recommend it."

Of the three, he says, the use of steroids is by far the most prevalent — and the most dangerous. "Nobody in an organized system supports anabolic steroids," he says. "For high school-age kids, these drugs are really taboo. They work, but they don't give you the edge at the high school level. The risk rate is just too high."

If a physician is present during an athletic event, it is likely that he will be called upon to treat a variety of ailments. Two relatively common occurrences — asthma and head and neck injuries — were discussed at the OSMA seminar.

"Exercise-induced asthma is very common," notes R. Trent Sickles, MD, Columbus. "It probably takes place in about 12 percent of the population."

If an athlete is diagnosed as suffering from asthma, there are several preventive measures that can be taken: The athlete can adopt a less strenuous exercise routine or exercise in air that has been humidified, concentrate on breathing nasally, reduce his breathing rate, and exercise at frequent intervals in order to take advantage of the refractory period which typically occurs 30 to 60 minutes after an asthma attack and can last up to several hours.

For the athlete who is unable to modify his routine, there are a

variety of medications available, including B_2 agonists, cromolyn sodium, theophylline and anticholinergic agents. Dr. Sickles notes that studies are also being conducted on calcium channel blockers, adrenergic receptor blockers and steroids.

With all the treatments now available, Dr. Sickles notes, "There's no reason why athletes should be discouraged from participating."

Another common, yet frequently-dismissed occurrence, is that of a blow to the head and/or neck.

"Ligament and muscle injuries can affect the athlete's career," notes Carole A. Miller, MD, Columbus, "but brain injuries can change their life."

If an athlete suffers a blow to the head or neck and is unconscious for less than one minute, Dr. Miller recommends the athlete be monitored closely for signs of headache, dizziness or seizure. If the athlete loses consciousness for one to five minutes, however — usually considered indicative of moderate brain injury — the athlete should be admitted to a hospital overnight and given a CT scan.

Furthermore, she notes, "You have to assume that any patient who's been knocked unconscious has probably suffered injury to the cervical spine as well."

Robert A. Bornstein, PhD, Columbus, points out that many symptoms associated with a head injury may persist days, or even weeks, later.

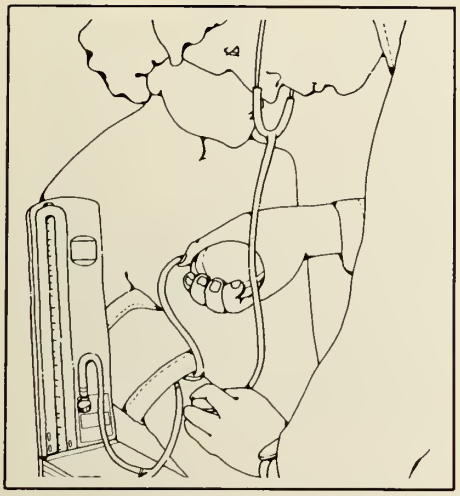
"These symptoms don't go away immediately," Bornstein says. "They're much more protracted." He adds that a subsequent injury could reactivate an old injury, producing symptoms a coach may mistake for silliness or giddiness. "It's clear that so-called minor head injuries aren't so minor," he says.

If an athlete suffers a blow to the head and is able to get up and walk away from it, Bornstein recommends the physician ask the athlete certain questions to determine if he is disoriented. If the athlete answers two or more questions incorrectly (for example, "What year is this?" and "What is your name?"), "he shouldn't be allowed to play," Bornstein says simply.

Ideally, Dr. Miller says, the physician should recognize the potential for injury and prevent it from happening in the first place. "When you see an athlete get (hit) and he's a little slow getting up, a little slow getting back in the huddle, he's at a greater risk for injury on the next play."

Of course, it shouldn't be the sole responsibility of the physician to prevent injury — athletes, coaches, trainers and parents should also be held liable. But until high schools are able to produce injury-free sports, it is in the physician's — and the athlete's — best interest to take an active interest in sport medicine's latest developments. **OSMA**





Treating Mild Hypertension

By Deborah Athy

The game, Medical Pursuit. The question: Assuming that nonpharmacologic methods have failed, at what level of diastolic blood pressure should a physician begin pharmacologic treatment for hypertension?

The answer . . . In a random poll of 20-30 physicians at a hypertension seminar held at the 1987 OSMA Clinical Update Meeting, nearly all pegged 95 mmHg. as the starting point for a drug regimen if all else fails. A few hands indicated a somewhat earlier level of 90 mmHg., and a lone physician opted for 85 mmHg.

With significant numbers of Americans battling hypertension — approximately 35 million — the question of whom should be treated is indeed timely.

Of the individuals with hypertension, 30% have blood pressure levels considered moderate to severe, while 70% have mild hypertension, with diastolic levels between 90 and 104 mmHg.

Most physicians agree that individuals with diastolic levels of 105 mmHg. and higher should be treated with medication and nonpharmacologic measures. For mild hypertension, many physicians begin with nonpharmacologic treatment, such as reducing weight, cutting alcohol and sodium intake, and increasing exercise. Only if these measures fail would physicians opt for a drug regimen, explains Ray W. Gifford, MD, a cardiologist at the Cleveland Clinic and moderator of the seminar.

But it's not really so cut and dried. Patients with diastolic blood pressure levels of 85-90 mmHg., the group dubbed "high normals," are more susceptible to increased blood pressure levels as they age. Which brings up the question: Can mild hypertension be controlled with medication, so that it will not progress into more serious ranges?

Perhaps the most worrisome factor is that patients in the 90-104 mmHg. diastolic range account for 58% of hypertensive fatalities, he says.

Other factors which complicate matters include smoking, heavy drinking, family history, high cholesterol, or mitral valve prolapse — all which can play significant roles in the patient's health.

For a closer look at these questions, Dr. Gifford highlighted several studies about mild hypertension.

The Veteran's Administration Cooperative Study, 1970

The study showed that

pharmacologic treatment reduced cardiovascular risks in severe hypertensives (115-129 mmHg.). While there was a reduction in cardiovascular risks for the 90-104 mmHg. range, the differences were not statistically significant. Drug treatment fared a little more successfully in the slightly higher — 104-114 mmHg. — group.

U.S. Public Health Service Cooperative Study

Of patients with blood levels between 90-115 mmHg., 43 on drug therapy and 98 on placebos had morbid events.

Medical Research Council Trial

This single-blind, placebo-controlled study compared the use of propranolol to bendro-fluazide. Stroke rates and cardiovascular events were reduced for patients in active treatment as compared to those on placebos.

Hypertension Detection and Follow-up Program (HDFP)

This study compared a five-year mortality rate for 10,940 study subjects between the ages of 30-69, including males, females, blacks and whites, all with diastolic blood pressure above 90 mmHg. Half were considered the "control" group and were referred to usual sources of care in the community, such as their private physicians. The others underwent treatment at HDFP centers, which included pharmacologic regimens. The researchers concluded that the HDFP individuals experienced a 20.3% lower death rate than the controls. Of those HDFP individuals with more severe hypertension, morbidity decreased by just 7.2% indicating that physicians were already treating this group more aggressively.

The HDFP study was the first to show that pharmacologic control of blood pressure prolonged life for patients with mild hypertension, says Dr. Gifford. In addition, the study suggests that drug treatment prevents the progression of hypertension, he says.

Most physicians don't treat diastolic blood pressure rates in the 85-89 mmHg. range, except perhaps with dietary controls. But the lone physician who opted for 85 mmHg. as a treatment starting point is probably ahead of his time, Dr. Gifford suggests. "Maybe in 10 years we will be treating this group."

If nonpharmacologic methods are not effective with individuals whose diastolic blood pressure is within 90-94 mmHg., then pharmacologic therapy should be initiated within six months, he continues. Physicians who elect not to use drug therapy for patients in this range should monitor their patients closely, because many will progress to higher levels of diastolic blood pressure, he points out.

"We must get more aggressive, even when the risk factors appear to be minimal," he concludes. "There's nothing mild about mild hypertension." **OSMA**

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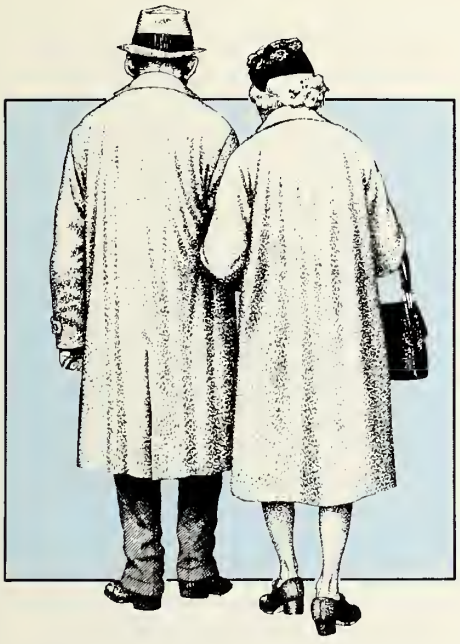
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The Woes of the Elderly . . . and How You Can Help

By Karen S. Edwards

By now, most physicians know that they will be seeing more and more geriatric patients in their practices. Along with the traditional aches, pains and other unpleasantries of aging, there are likely to be other maladies of which physicians need to be aware.

For example:

Elderly depression

Depression in the elderly is hardly a new medical subject. According to Philip E. Hinkle, MD, Director of the Geropsychiatry Programs at Riverside Hospital in Columbus, and a speaker at the recent "OSMA Clinical Update" meeting, held this past September, the subject dates as far back as the Book of Job, and has been mentioned by different notables throughout history, including Hippocrates and the 17th-century English author, Robert Burton.

Yet depression in the elderly continues to occur frequently today, giving rise to a suicide rate that increases, proportionately, with age — "and despite the press that is given to teen suicides," comments Dr. Hinkle.

Physicians who see elderly patients might want to note some of the signs and symptoms which seem to indicate that the patient is — or might be — depressed.

According to the DSM III — the typical evaluating mechanism to determine a major depressive episode — a patient has to have a dysphoric mood and/or a loss of interest or pleasure. Generally, this type of behavior manifests itself in the following symptoms:

- insomnia or hypersomnia
- poor appetite or a weight loss or gain
- psychomotor agitation or retardation
- loss of interest or pleasure in activities
- loss of energy/fatigue
- loss of ability to think or concentrate
- thoughts of death or suicide
- feelings of self-reproach or guilt

If a patient exhibits at least four of these symptoms for a period of two weeks or more, and the symptoms can't be explained by an organic mental disorder, bereavement or schizophrenia — then chances are the patient is depressed.

"There are also medical disorders that are associated with depressive symptoms," says Dr. Hinkle. He urges physicians to look for and exclude: toxic-metabolic disturbances, CNS disorders, infections (like hepatitis

and influenza), collagen-vascular disease and neoplastic disorders before labeling a patient depressive. In addition to ruling out medical disorders, a physician should also check to see whether or not he or she is on medication, says Dr. Hinkle. At least half of the ten most frequently prescribed drugs are drugs which can cause depression — Inderol, for example, as well as Lanoxin, Valium, Tylenol with Codeine and Tagamet. "Remove the offending agent and you may remove the depression," says Dr. Hinkle.

While depression can be tricky to diagnose, however, diagnosing melancholia can be just as bad.

"Melancholia has a tighter criteria," explains Dr. Hinkle. The patient with melancholia will generally present with anhedonia and a lack of reactivity. In other words, he says they are no longer experiencing pleasure or fun. Like depressive patients, they are likely to appear in the physician's office with multiple symptoms — usually three or more from the following list:

- early morning awakening
- anorexia and/or weight loss
- psychomotor agitation or retardation
- they will feel worse (most depressed) in the morning
- guilt (usually delusional)
- a distinct quality to their depressed mood ("Not like the kind of depression that goes with bereavement," explains Dr. Hinkle.)

There are also a typical presentation of a major depressive episode — ones that are often overlooked by physicians. For example:

- apathy
- hypochondria
- unexplained weight loss and
- pseudodementia, where the patient's cognitive ability may not be at its best.

Treatment of the elderly depressed must be accomplished in a multifaceted way, says Dr. Hinkle. "There needs to be social, physical and psychological intervention," he says.

Melancholia, however, needs biological treatment, and Dr. Hinkle cautions physicians to select antidepressant drugs that lack — or produce — a minimum of side effects.

"The elderly are very sensitive to side effects," he says, adding it's best to stick with the basic tricyclics when prescribing.

Alzheimer's

As the population continues to age, Alzheimer's disease and other dementias are rapidly becoming a major problem. One of the medical profession's biggest worries, of course, is that Alzheimer's is 80% untreatable. Another worry is the disease's etiology. No one seems to know exactly what causes dementia in some people and not others — but there are theories, says James N. Kvale, MD, Associate Professor, Division of Geriatrics, St. Elizabeth Hospital, Youngstown, and another speaker at OSMA's "Clinical Update" meeting.

Present theories include: delayed viral sensitization, toxic response, immune mediated phenomenon, genetic factors and advanced parental age — but right now, there is no good episodic evidence or studies to support any of them.

"However, it is known that if one parent has the disorder, there is a less than 10% chance that the offspring will develop dementia," says Dr. Kvale. On the other hand, if both parents have the disorder, the probability of the offspring developing dementia increases to 25%, he adds.

Experts believe that the incidence of dementia in this country is high, but that it often goes unreported. That may be because diagnosis is so difficult to make, notes Dr. Kvale.

"It is a diagnosis of exclusion," he says.

He recommends that physicians begin their diagnosing process by taking a complete history. "You need to know what has happened to the patient, the step-wise deterioration of the cognitive function. Family statements are crucial." A physical exam, including a careful neurological exam, lab and X-ray tests and a neuropsychological assessment are also important, he adds.

And there is one thing you can count on, he continues. "By the time the family brings the patient into your office, the dementia is usually well underway."

"Well underway" means that the disease may be well into Stage I — a level of the disease that may last from two to four years and include progressive memory loss and cognitive failure; personality change; impairment of judgment and awareness; disorientation; and depression.

"Spouses say the relationship is profoundly changed at this level," says Dr. Kvale, despite the fact that there are two more levels yet to come.

In Stage II, (which can last anywhere from three to four years or six to ten) memory impairment and cognitive functions worsen; there is wandering behavior; hyperkinesis; disturbance of both sleep and appetite; incontinence of bowel and bladder; and decreasing ability to perform the activities of daily living.

Finally, in Stage III, the patient

"Treatment of the elderly depressed must be accomplished in a multifaceted way — social, physical, psychological intervention."

is usually bedfast, and there may be immunoincompetence and neurologic regression.

The disease is long-term, with an eight- to twenty-year prognosis, says Dr. Kvale, but "the younger you get it, the quicker you die," he adds.

As far as managing the disease — in the first stage, the physician can treat the patient's depression, but Dr. Kvale encourages physicians to give the family caretakers "all the support you can."

"Families do not abandon their loved ones," he says.

It's also a good idea, at this stage, to help the family deal with legal issues — powers of attorney, etc. "Ask them to think about what would happen if the party who has power of attorney precedes the Alzheimer patient in death," suggests Dr. Kvale.

He also says physicians should help the family confront the inevitable denial that their loved one is a victim of dementia. "Help them find a support group, respite care, a day hospital or books on the subject," And warn them that these patients should not be driving cars, tractors or other vehicles. "Hold these discussions in front of the patient so he or she knows the limitations," Dr. Kvale says.

In the second stage of Alzheimer's there will be increased need for supervision.

"Treat psychoactive substances with caution," says Dr. Kvale, recommending that patients not be given Valium or Dalmane which are hard for elderly patients to eliminate. Instead, he suggests Haldone in small doses.

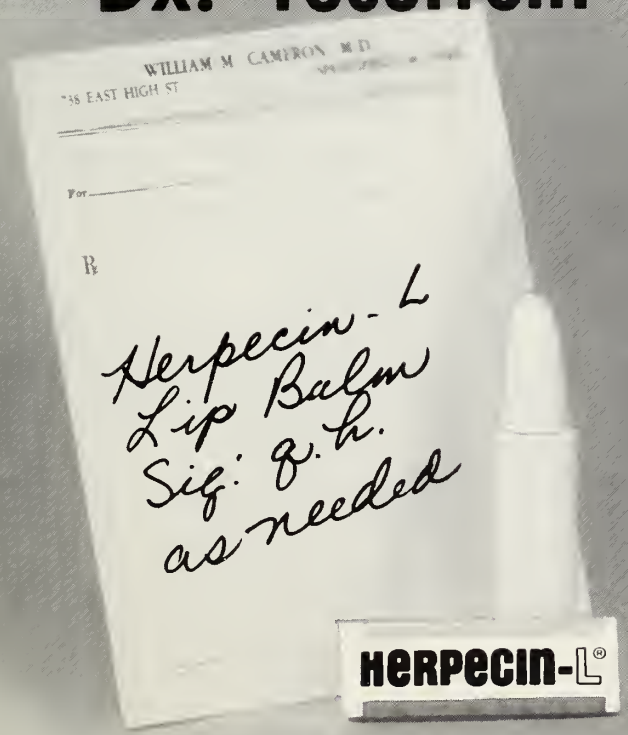
As far as the nutritional needs of the patient are concerned, "do the best you can, maintaining fluid intake," Dr. Kvale says.

At this stage, almost universally, there is depression in the support system. This is when the family is likely to pack the patient's bags and drop him or her off at the nearest emergency room — usually an unpopular move with the house officers. "In our hospital, I try to convince our house officers that they are being involved in a very complex matter, and I try to get them to exercise some understanding." Admission to the hospital, even on an intermittent basis, can provide respite care to the caregiver, he says.

In the third stage, Dr. Kvale encourages families to support the patient in the home as long as they are able, but, eventually, institutional or nursing home care is inevitable.

"The disease must be regarded as terminal," he concludes. **OSMA**

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Drug Overdose and the Elderly

By Michelle J. Carlson

Drug overdose in the elderly — it's a subject that isn't broached very often, but Ohio health-care workers appear to agree: It's a widespread problem with serious, sometimes dangerous, implications.

"Elderly drug use, abuse, misuse and overdose has been a major concern for some time," says Claire V. Wolfe, MD, Dublin. "It's just been in the past few years that it's been getting the press and attention it deserves." Dr. Wolfe and several colleagues were in Columbus recently to address the issue, "Overdose in the Elderly: An Interdisciplinary Concern," during the OSMA's annual Scientific Meeting.

Dr. Wolfe prefaced the meeting by providing statistics that show elderly people (those over age 65) account for 25 percent of total drug expenditures in this country and 29 percent of overall health-care expenditures — yet their ranks account for only 11 percent of the total population.

In addition, she noted that many elderly patients take as many as eight or more prescription medications per day, which are often prescribed by two or more doctors.

While the situation is slowly being acknowledged as a serious one, only recently has the medical community as a whole begun to accept joint responsibility for correcting the problem.

Indeed, notes Geraldine Price, RN, Columbus, "It's not a matter of blaming (one another), it's a combined ownership of the problem. Pharmacists, doctors and nurses all have to take responsibility."

Patients also must recognize the importance of taking their medication as it is prescribed, she adds.

Phyllis Wilson, RPh, Hilliard, warns her colleagues of the "unpredictable response to drugs" many elderly patients have, and she discourages physicians from practicing automatic drug use — prescribing medication for a recurring or chronic condition without first fully assessing the patient's condition.

She also recommends the medical community ask itself several specific questions before prescribing or administering drugs to elderly patients: Is drug therapy absolutely required? Is the choice of drug appropriate? Is the dosage correct? Have all necessary tests been ordered? Is the drug's form (tablet, capsule, liquid, etc.) appropriate? When should drug therapy be halted?

By running through a mental checklist — and making changes when necessary — Wilson predicts that the incidence of overdose in the elderly will be greatly reduced.

But even when the physician

takes every precaution when prescribing medication for an elderly patient, there remains the potential for drug misuse and abuse.

Edward T. Bope, MD, Columbus, notes that because the elderly often face a variety of physical restraints — failing eyesight or poor flexibility, for example — it is important that the physician recognize his or her patients' limitations and act accordingly.

Dr. Bope says some of the problems elderly patients face include the inability to read prescription labels clearly, the inability to open bottles and split tablets, and the inability to follow strict medication schedules.

While the private physician cannot possibly be expected to constantly monitor his or her patient's every move, he or she can offer suggestions and advice that will ensure responsible drug use.

Marlene Hollstein, RN, Swanton, suggests physicians minimize the problem by paying special attention when devising medication schedules (for example, by prescribing a schedule that coincides with a patient's television viewing habits), by providing easy-to-open prescription bottles, and by contacting the patient's family on a regular basis.

By following these guidelines, she says, a physician can feel relatively confident that the patient will take his or her medication in accordance with the schedule and quantity prescribed.

Overdose in the elderly, however, is by no means confined to the elderly patient living at home, as several panel members demonstrated by addressing the issue from a nursing home perspective.

Health-care professionals, says Ramond Pongonis, DO, Columbus, must realize the special needs and characteristics of their nursing home patients.

"You have to remember that aging and the onset of disease are not necessarily synonymous," Pongonis says, "so drug therapy and the elderly is unpredictable. That in itself should encourage individual assessment of each patient."

Unfortunately, he adds, many doctors see their elderly patients so infrequently — often just before admitting them to the nursing home — that the role of the nursing home nurse or nurse's aide has become much more important.

"Even though the doctor writes the prescription, you still have to watch these patients very carefully," he warns. "Nurse aides have a big responsibility because they're with elderly patients all day monitoring them."

Health-care workers, he stresses, should strive to correctly identify all medications, minimize delays when clarifying drug orders, identify medical diagnoses, continually monitor patients, and actually witness patients taking medications.

"That mission sounds so simple," he says, "but sometimes we fail miserably. The whole health-care team in the nursing home setting is needed to combat this problem."

Pongonis also echoes Price's warnings against the practice of overprescribing. Often, he says, doctors and nurses may be tempted to medicate a patient who appears listless, anxious or agitated, when in fact, behavior modification or some alternative therapy may be indicated. In his own practice, Pongonis says, "I ask myself, 'Who am I really treating?' Are we treating the patient or are we treating the nurse or the doctor?"

While Debbie Freece, RN, Columbus, agrees that doctors and nurses occasionally make errors in judgment, she suggests that some of the problem lies within the system itself.

Because stiff regulations require that nursing homes staff themselves with a specific number of nurses and aides for every 100 residents, it's no surprise that many facilities are feeling the financial crunch, she says. While some may choose to hire temporary or part-time help, others may simply insist that the regular staff absorb the extra work.

Either way, she says, it's possible that the quality of patient care will suffer.

While Freece admits that hiring temporary nurses "can be a very competent practice if you have the same temporary returning to the facility every day," hiring part-time nurses can be a trickier proposition.

On the one hand, there is no denying that a part-time nurse will lessen the load of an already-overburdened, full-time nurse. On the other hand, Freece says, "What often happens is the part-time nurse can't always recognize problems with patients because she doesn't see them often enough."

Perhaps the worst solution, however, is to simply require regular staff members to pick up the extra work, since overworked, short-handed staff members are more likely to commit errors in judgment that could compromise a patient's health.

The actual administration of

continued on next page

Some of the problems elderly patients face include the inability to read prescription labels clearly, inability to open bottles, split tablets, follow strict schedules.

medication to patients can also pose problems in the crowded atmosphere of the nursing home, she says.

"What we are seeing is when there's a large number of residents, most medications are given at one time in the dining room," Freece says. This practice is open to abuse, especially when the ratio of nurses and aides to patients is inadequate, because the staff may not be able to monitor every patient's intake of medication. Furthermore, patients have been known to steal other patients' medications, which can result in serious problems, she says.

Other problems nursing home employees may encounter include poor communication with patients' doctors, difficulty interpreting a patient's behavior or condition from one shift to the next, and lack of appropriate patient screening prior to admission to the nursing home.

Besides coping with administrative and logistical snafus, the nursing home staff must also concern itself with a myriad of details.

Freece recommends that staff members pay special attention to the time a drug is to be administered to a patient, ensure that it is the correct drug and form, and that the patient's medication is actually administered. Nurses must also be on the lookout for unordered medications, standing orders and errors in transcribing prescriptions (misreading .05 mg for 5.0 mg, for example).

Physicians can ease the strain by conducting regular drug reviews of their patients.

Physicians can ease the strain on the nursing home staff by conducting regular drug reviews of their patients (to assure that patients are not being overmedicated or taking incompatible — or deadly — combinations of drugs) and establishing on-call hours for the convenience of the staff.

However, Freece says, there are still hurdles to overcome.

"There are a lot of glitches in the nursing home system," she says. "There's a lot of places where something can go wrong."

While stories of drug abuse among the elderly are bound to persist, admitting that a problem exists is half the battle won — and the Ohio medical community appears to have done just that. **OSMA**

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Recognizing Depression

in the Primary Care Patient

By Deborah Athy

A new patient shows up in your office with symptoms including fatigue, weight loss, sleeping difficulties, irritability and depressed mood. She says the days sometimes seem to stretch endlessly in front of her, with no relief in sight. She admits to drinking too much coffee and taking an occasional Valium.

Assuming these symptoms had no biological basis, participants at a "Depression in the Primary Care Patient" seminar noted that the woman displays some of the classic symptoms of depression. Psychiatrists and primary care physicians met at this 1987 OSMA "Clinical Update" workshop to brainstorm similar office scenarios and discuss methods for recognizing covert depression.

Depression is an enormous public health issue, affecting at least 10 million Americans, according to Daniel A. Deutschman, MD, a Cleveland psychiatrist and moderator of the seminar. Statistics suggest that 25% of women and 10% of men wrestle with depression at some point in their lives.

Today's society produces a significant amount of stress and pressure, with occurrences such as the breakup of the family, higher divorce rates, financial concerns and increased substance abuse. In fact, an estimated 30% of primary care patients have a diagnosable psychiatric disorder that is often related to stress and anxiety, says Dr. Deutschman.

Most primary care physicians recognize stress-related elements in their patients, he continues. But only a small number of these patients are diagnosed with depression by their physicians, suggesting there may be a "missing link" in the mental health network that could be secured, he says.

Picking up on depression is something akin to reading between the lines, or, as the case may be, listening between the words. "You've got to listen with a third ear. You've got to listen hard," he explains.

Physicians, however, work in a time-intensive, high-pressure environment — one that is generally more conducive to a biological approach to illness rather than to lengthy discussion. But essential information can be culled by taking a thorough medical history, although this may require more time than a typical visit.

Taking a good history involves

recording information such as length and duration of symptoms, past and present medical and psychiatric illnesses of both patient and family, evaluation of behavior, mood, speech and judgment, as well as a physical exam and necessary lab tests.

"Medical problems have to be evaluated and ruled out," Dr. Deutschman emphasizes.

Physicians may have success with a supportive psychotherapeutic approach, or letting patients freely express themselves during the history-taking process, he suggests. Depressed patients often will express their feelings and thoughts quite readily, he adds.

If a patient begins to complain about a battery of vague, persistent symptoms that appear to have no medical basis — sudden change in weight, loss of libido, suicidal thoughts, sleep and concentration difficulties — he or she could be a candidate for depression.

"Diagnosing depression is exactly like any other area of medicine in that you may detect a sign that something is not as it should be. You have to develop a high index of suspicion," he says.

But take care to clarify these symptoms, he cautions. For example, a change in sleeping patterns could be caused by a new work schedule or medication.

Dr. Deutschman also cautions physicians to be aware of substance abusers who dip into drug use to mask their depression, even from themselves. "Drug problems are so prevalent today that I almost always ask about usage. You'd be surprised who uses cocaine and other drugs." Patients may use drugs or alcohol as a method to treat their underlying depression, Dr. Deutschman points out.

If you determine that the patient is clinically depressed, you have several options, depending on the circumstances. Most primary care physicians have working relationships with several psychiatrists and may opt to refer the patient.

"We want to move in a direction where primary care physicians feel more comfortable in contacting a psychiatric colleague for reassurance that they're going in the right direction," he explains.

Some primary care physicians prefer to treat psychiatric problems themselves, using a combination of antidepressive medication and counseling in the framework of a standard medical visit.

In any case, with suicides numbering an estimated 50,000 per year, physicians must quickly attempt to assess the seriousness and extent of the situation.

"It's very difficult to predict dangerousness or to give a correct assessment of suicide risk. It is an area which is sort of an art, because there are no qualitative tests. The best one can do is to get as clear an understanding as possible of how ill the patient really is."

In the past, physicians didn't talk to their patients about suicide, perhaps assuming that if it wasn't talked about it wouldn't happen. But these old myths have been overhauled, he says — and none too soon, considering that some reports indicate that most suicidal patients see their primary physicians within three months of their suicides.

"Sometimes you have to come right out and ask, 'Has it gotten to the point that you've thought of hurting yourself? Do you have a plan? What would you do?' If you feel in your heart that someone should be in the hospital, go with your feelings. People who are suicidal flat out need to be in a hospital," he recommends.

But many individuals harbor old stereotypes and built-in reservations about mental hospitals. You may want to suggest that the patient get a second opinion, an option most patients will agree to, Dr. Deutschman says. For example, you could contact a psychiatric colleague or send the patient to an emergency room, depending on the urgency of the situation.

Sometimes an empathetic approach is helpful, such as: "Seems like things aren't going the way you'd like them to. Maybe it would be a good idea to get away from all this stress for awhile. Maybe the thing to do would be to go to a hospital for a short time. Maybe we could call your wife or someone in your family to take care of you."

This approach and method of questioning could be discerned as bordering on manipulation, Dr. Deutschman admits. But a key issue is to avoid allowing the patient to dictate the terms. "Getting the patient to promise not to do anything harmful is a losing battle. They (suicidal patients) are not in a position to promise anything to anybody. I would rather not take the chance," he states.

Another psychiatrist at the seminar concurred, by pointing out: "I've gotten in the most trouble when I let the patient manipulate me."

In the past, the extent of a primary physician's education on mental illness focused more on the state hospital patient, Dr. Deutschman concludes. "Now we're trying to recognize the everyday patient who is suffering unnecessarily." **OSMA**

If a patient begins to complain about a battery of vague, persistent symptoms that have no medical basis — he or she could be a candidate for depression.

Recommendations for Preventing Possible Transmission of HIV from Tears

Human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the etiologic agent of acquired immunodeficiency syndrome (AIDS), has been found in various body fluids, including blood, semen and saliva. Recently, scientists at the National Institutes of Health isolated the virus from the tears of an AIDS patient.[1] The patient, a 33-year-old woman with a history of *Pneumocystis carinii* pneumonia and disseminated *Mycobacterium avium-intracellulare* infections, had no ocular complaints, and her eye examination was normal. Of the tear samples obtained from six other patients with AIDS or related conditions, three showed equivocal culture results, and three were culture-negative.

The following precautions are judged suitable to prevent spread of HTLV-III/LAV and other microbial pathogens that might be present in tears. They do not apply to the procedures used by individuals in caring for their own lenses, since the concern is the possible virus transmission between individuals.

1. Health-care professionals performing eye examinations or other procedures involving contact with tears should wash their hands immediately after a procedure and between patients. Handwashing alone should be sufficient, but when practical and convenient, disposable gloves may be worn. The use of gloves is advisable when there are cuts, scratches or dermatologic lesions on the hands. Use of other protective measures, such as masks, goggles or gowns, is *not* indicated.
2. Instruments that come into direct contact with external surfaces of the eye should be wiped clean and then disinfected by: (a) a 5- to 10-minute exposure to a fresh solution of 3% hydrogen peroxide; or (b) a fresh solution containing 5,000 parts per million (mg/L) free available chlorine — a 1/1.0 dilution of common household bleach (sodium hypochlorite); or (c) 70% ethanol; or (d) 70% isopropanol. The device should be thoroughly rinsed in tap water and dried before reuse.
3. Contact lenses used in trial fittings should be disinfected between each fitting by one of the following regimens:
   a. Disinfection of trial hard lenses with a commercially available hydrogen peroxide contact lens disinfecting system currently approved for soft contact lenses. (Other hydrogen peroxide preparations may contain preservatives that could discolor the lenses.) Alternatively, most trial hard lenses can be treated with the standard heat disinfection regimen used for soft lenses (78-80 C [172-176 F] for 10 minutes). Practitioners should check with hard lens suppliers to ascertain which lenses can be safely heat-treated.
   b. Rigid gas permeable (RGP) trial fitting lenses can be disinfected using the above hydrogen peroxide disinfection system. RGP lenses may warp if they are heat-disinfected.
   c. Soft trial fitting lenses can be disinfected using the same hydrogen peroxide system. Some soft lenses have also been approved for heat disinfection.

Other than hydrogen peroxide, the chemical disinfectants used in standard contact lens solutions have not yet been tested for their activity against HTLV-III/LAV. Until other disinfectants are shown to be suitable for disinfecting HTLV-III/LAV, contact lenses used in the eyes of patients suspected or

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AIDS Guidelines...*continued*

known to be infected with HTLV-III/LAV are most safely handled by hydrogen peroxide disinfection.

The above recommendations are based on data from studies conducted at the National Institutes of Health and CDC on disinfection/inactivation of HTLV-III/LAV virus.[2-4] Additional information regarding general hospital and laboratory precautions have been previously published.[5-9] Reported by the U.S. Food and Drug Administration; National Institutes of Health; Centers for Disease Control. **OSMA**

Editorial Note: *All secretions and excretions of an infected person may contain lymphocytes, host cells for HTLV-III/LAV; therefore, thorough study of these fluids might be expected to sometimes yield this virus. Despite positive cultures from a variety of body fluids of infected persons, however, spread from infected persons to household contacts who have no other identifiable risks for infection has not been documented. Furthermore, there is no evidence to date that HTLV-III/LAV has been transmitted through contact with the tears of infected individuals or through medical instruments used to examine AIDS patients.*

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continued on page 882

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Laser Medicine: When You Need It, When You Don't



By Leon Goldman, MD

Introduction

For this brief review, it is important to know that lasers, in spite of their great powers, are still forms of light. This light ranges from the far infrared to ultraviolet. Current research also demonstrates that it is possible to produce X-ray lasers which could make three-dimensional images (holography) of atoms and molecules, and which could be used for cancer therapy. A free electron-beam laser instrument is to be used shortly for bio-medical applications. This single instrument has special pulse characteristics and multiple wave lengths.

The laser, a so-called optical scalpel, can operate continually, or for short periods of time called pulses. The duration of these pulses can range from milliseconds through so-called Q-switched or nanoseconds (10-9) to femtoseconds (10-15). Short pulses limit the laser tissue reaction to precise local areas — even to removal of a single melanocyte or single endothelial cell, causing laser surgeons to dream of so-called atraumatic surgery. Microsurgery has also had a renaissance through lasers as light beams are transmitted through the optics of a microscope.

The chairmen of the various sections of the American Society of Laser Medicine and Surgery review and classify the applications of their respective disciplines as follows: obligatory, preferred and not to be used. These lists of the surgical applications of various laser systems are determined by many factors, including the state of the art; experience with adequate controls; follow-up studies; regulations of the FDA; research findings; the professional training of the surgeon; the needs of the community; and the economics of the laser program. Clinical experiences of qualified investigators in foreign countries (with FDA supervision) are but some of the additional factors



The laser medical market is expected to expand annually at 30% — a higher percentage than that expected of either industrial or military applications.

which can determine the use of laser surgery.

Safety

The first phase after an instrument is considered for medical use is the study of safety. The eye is sensitive to the special qualities of lasers, so a specific program must be developed both for the patient and the operator. The program for laser safety is developed through the American National Standards Institute Committee for the Safe Use of Lasers in Medical Institutions.

Laser Ophthalmology

The first medical application of the laser was for ophthalmology. Here, a beam from a ruby laser was focused through the lens of a patient to tack down the peeling of retinal detachment and to stop it. Then, the laser was used for volatilization of blood, and to arrest bleeding as detected by fluorescein.

The second laser, the argon, was used primarily for neovascularization, especially for the young diabetic.

Next in the development were various lasers used to treat glaucoma. These included the ruby and argon laser. Recently, the Neodynium Yttrium Aluminum Garnet (NdYAG) laser has been used. This laser, in the near infrared, is used chiefly in very short pulses for opening up the cloudy posterior capsule after lens implantation following cataract surgery. Occasionally, a cloudy anterior capsule may also be so treated.

Progress in laser ophthalmology continues today with current studies with excimer lasers. The excimers have a very superficial cutting action and are very precise. The current experimentation is for radial keratotomy, astigmatism and corneal transplants. The concern about these lasers, in the near ultraviolet, is whether or not they are mutagenic. It must therefore be determined which of the wavelengths may be carcinogenic and which may not, so that medical applications may be available. Another recent development in laser ophthalmology is the use of femtosecond pulses.

In the meantime research continues in laser diagnostic instrumentation. An example of this is the current Scanning Laser Ophthalmoscope (SCO), a low-light, ocular fundus camera and an ophthalmoscope which provides an enlarged image of the eye itself and the dynamics of the blood vessels in the fundus. This fascinating instrument can be used for studies of capillaroscopy and, with its ability to scan fluorescence, can be used in scanning the laser-induced fluorescence of today's photodynamic therapy (PDT) program for cancer diagnosis and treatment.

Introduction to the Various Disciplines of Current Laser Surgery

With the continued development of portable, flexible, reliable and safe laser units, laser surgery can frequently be performed in the office (save for general anesthesia). In fact, with a new 12 kg. suitcase-sized, battery-powered CO_2 laser and adequate output, CO_2 laser surgery may be done in the home and in nursing home facilities when bedside laser surgery is indicated. The various areas of current laser surgery will be reviewed briefly.

In the current laser market, for example, these are the four leading commercial leaders: ophthalmology, gynecology, dermatology and, curiously, podiatry (the profession is making great efforts to prevent the wide and wild abuse here). However, the laser medical market is expected to expand annually at 30% — a higher percentage than that expected of either industrial or military applications.

Dermatology

The obligatory applications here for laser surgery are the port-wine marks and various types of vascular lesions; extensive, resistant warts; and florid condylomata acuminata. Instruments for laser dermatologic surgery include the current argon, CO_2 and NdYAG. The new ones are the heavy metal vapor lasers — the copper vapor (CVL) and the gold head. A new laser, used for some time in Germany, is the 577 nm, whose duration of impact is very short.

Recent investigations indicate that the best treatment for the usual type of port-wine mark is the 566 nm (or the flash-lamp, pumped-dye laser) with short pulses. However, present routine treatment uses the argon and the

copper vapor lasers. With deep, mixed, port-wine marks, the CO_2 and the NdYAG may be used in addition. Test treatments are usually given to a peripheral area, then it is customary to wait two to three months for a critical review of the treatment. At rare times, the whitening after the test treatment may extend far beyond the target spot. For flat lesions, excellent waterproof covering creams are available.

In laser dermatology, the treatment of port-wine marks is most gratifying, even though the results may be only a slight improvement or only make for easier cosmetic covering. The patients should be warned, however, not to expect miracles because of the intensely deep vascular structures of the port-wine mark. Scarring after laser treatment may develop especially about the nose, lip and chin.

In addition, not only benign but also malignant vascular tumors are treated by lasers, and resistant warts are usually treated with the CO_2 laser. For extensive condylomata acuminata in the male and female, CO_2 laser surgery is superior to high-frequency electro-surgery or to chemotherapy with podophyllin, since bleeding occurs less frequently, especially in the pregnant patient. Examination with the colposcope, a clinical stereo microscope, is necessary for detecting early lesions and for follow-up in the post-operative patient. The colposcope also makes for differential diagnosis of lesions which look like warts (such as polyps, hemorrhoidal tags, seborrheic warts and condylomata lata).

Plastic Surgery

Laser plastic surgery offers special services which are beyond the capability of the dermatologic surgeon. Laser plastic surgeons, for example, have shown the value of the laser excision of massive angiomas, graft transplants for laser lesions and hand surgery.

Should *your* community develop a laser center?

Editor's note: *Is there a laser treatment center in your community? If not, you may want to note the points made here by Kay Ball, RN, of the Grant Hospital Laser Center, Columbus, on what to consider before initiating such a center in your own community.*

When a facility makes the decision to initiate a laser center, several practical steps are necessary to make this venture successful. Careful planning, including input from facility officials and physicians, must be completed. In order to develop this program, the concerns and interests of each party must be assessed and evaluated. Physicians are especially important since they are ultimately the decisionmakers of whether the laser will be used for a procedure. The physicians, based on their diagnoses and referrals, will actually determine the case load of the laser center. Health-care facility officials are also an important part of the planning process due to the long-term commitment. The facility must evaluate the proposed program and assess its direction and needs. Through cooperative efforts of the administration, physicians and laser team, goals and objectives must be set for the laser center and communicated to all those involved.

The planning process should also involve a comprehensive survey of community needs and local competition. Depending on the predominance of a certain age or sex, various uses for the laser may be more popular. Also, other health-care facilities in the area must be surveyed regarding laser centers or equipment that may already exist. If other programs do exist, the analysis of the community and referring physicians will determine if the need is great enough to support an additional center. The possibility of joining with other facilities to form a laser center is also an option. This cooperative effort can possibly reduce initial costs while providing consistency and growth of laser technology within a geographical area. Once all of the planning and survey data has been collected, facility officials must evaluate the information and make the decision whether or not to begin a laser center. — *Kay Ball*



New lasers will include excimer, short-pulsed ultra-violet lasers, free-electron beam lasers, perhaps even X-ray lasers.

Experiments have also been done for microvascular welding of blood vessels. Now, the plastic surgeons are investigating peripheral nerve welding. The 532 nm laser is also under investigation as a rival to the high-output argon and copper vapor lasers.

The treatment of tattoos is another preferred laser therapy and has been so for some 24 years. Short-pulsed ruby lasers are excellent for blue and black areas, argon for red areas. The CO_2 laser can be used for all colors, although 10% or more scarring may occur after CO_2 laser use. Continued pressure bandages and repeated injections of suspensions of corticosteroids will help to prevent or reduce the intensity of the scarring.

Laser Gynecology

For the cancer control program, in general, and for laser gynecology, in particular, there is the laser treatment of preinvasive cancer of the vulva, vagina and cervix. This is ambulatory therapy with early diagnosis by the colposcope, especially by abnormal submucosal vascularizations. Other examples of laser gynecology include tuboplasty for infertility, laparoscopy and the treatment of endometriosis. Photodynamic therapy for early and even inoperable cancer is also done. However, control studies are still needed to compare laser surgery with other modalities such as cryosurgery and other accepted forms of treatment.

Head and Neck Surgery

The early applications in this specialty came with the obligatory laser surgery of laryngeal polyps and cancer. For head and neck cancer surgery today, basic detailed experiments have shown the value of PDT therapy for cancer diagnosis and treatment.

Laser Urology

Laser urology is used chiefly for cancer treatment programs, especially with the photodynamic laser therapy of induced fluorescence. Here, transitional cell cancer is selectively treated by a 628 nm laser beam fiber through a cystoscope. Although the entire bladder is exposed to the laser, the uninvolved mucosa is not affected — only the cancer. Laser urologic surgery is being investigated now for the fracture of calculi, nephrectomy and prostatectomy.

Laser Gastro-Intestinal Diagnosis and Treatment

In brief, the laser program here is laser endoscopy for diagnosis and treatment. The argon laser was the first one used, then the NdYAG. The copper vapor laser is under research protocols now. Continued research in fiber optics, which transmit the laser beam, will continue to make these endoscopes even more effective. As a current example, fiber optics transmission of the CO_2 laser will make CO_2 laser surgery more flexible in any application. (Both abdominal surgery and hemorrhoidectomies have been performed using the CO_2 laser.) Research on the development of micro-holographic instrumentation to give third-dimensional imagery at the tip of the endoscope is also a future possibility.

In clinical investigations in the gastro-intestinal field, argon laser-induced laser fluorescence for cancer diagnosis and treatment is under investigation for gastric and colonic cancer. Even the argon laser and topical toxic acridine orange have been used as PDT therapy for early gastric carcinoma.

Laser Cardiovascular Surgery

Lessened bleeding has been a property of all laser surgical systems today, and for over 25 years, yet only recently have studies been done on laser effects on platelets and disturbances of platelets' function. Laser Doppler flowmeters have been developed. Basic studies of laser impacts on atheromata, blocked coronaries and blocked carotid vessels have also been performed.

Again, the excimer ultraviolet laser, with its short pulses, has been used for treatment of experimental atheromata, and again, because of the superficial character of the impact and its precise nature, there is an avoidance of thermal damage to the adjacent intima and perforation of the vessel wall.

As a test model for argon laser intravascular surgery, a mini-intravascular argon probe has been developed for the disturbing telangiectasic "sun burst" on the thigh and legs. Adjacent controls have included 20% saline as sclero-therapy and intravascular galvanic currents for 27- and 30-gauge needles with 0.8 MA for 1 second. There is no doubt that laser angioplast is of interest. However,

this procedure needs many controls, more basic studies and prolonged periods of observation.

Laser Neurosurgery

Great progress has been made in laser neurosurgery. There is definite, obligatory surgery for certain hard tumors and definite indications, again with PDT programs (especially post-operative), to evaluate the operative laser brain tumor surgery done. Laser neurosurgeons are doing research on laser endurterectomy.

Laser Orthopedic Surgery

In the clinical phase today, laser arthroscopes have just been developed to determine if these are truly necessary for laser surgery. Laser sternotomy has been done in cardiovascular surgery. Laser research also continues on the polymerization of plastics for orthopedic surgery. (However, laser bone surgery does produce extensive charring.) Rapidly-done bone-cutting, so desired for bone surgery in the elderly patient, is still being investigated, but laser orthopedic surgery has proven itself to be of great value in bone and joint surgery in hemophiliacs.

Laser Nonsurgical Medicine

This is a rapidly developing new discipline which includes such basic factors as laser photobiology, laser immunology with cell-sorter systems, cytofluorometry, monoclonal antibodies, laser nephelometry, thrombogenesis and thrombolysis by lasers and cardiovascular diagnosis and treatment. Laser treatment of some infections, a much-abused phase of study, usually without any controls, has been done chiefly for viral infections, especially with the HSV Type II, and even for chronic infections, like tonsillitis.

This brings up the whole subject of "biostimulation." It has become a very popular subject at the present time, with the following low-output lasers being used: Helium neon, Krypton, junction diode 904 nm and even low-output CO_2. The uses are chiefly for pain relief and for physical therapy. These usually uncontrolled studies are more popular in Europe than in the USA.

Biostimulation is used all over the world, chiefly with anecdotal, subjective responses and, as indicated, without controls. Few objective tests have included changes in local thermography and capillaroscopy. There is only one way to make sense out of all this confusion — by well-controlled protocols enacted by qualified investigators and by critical reviews by the new neurophysiology group at the FDA. Such studies must be done if discussions about biostimulation are to be carried on with more light and less heat.

Future

As indicated, the future is great for laser medicine and surgery. New lasers will include excimer, short-pulsed ultraviolet lasers, free-electron beam lasers and perhaps even X-ray lasers. Laser systems will combine computer technology — including medical robotic technology. The role of the laser in MRI (magnetic resonance imagery) will be of great importance. In MRI, the laser is under investigation for improving the imagery with the development of holographic, or third-dimensional imagery, and, for the visceral functional studies of MRI, the help will be from laser spectroscopy. MRI will differentiate between ischemic and nonischemic areas of the heart.

Laser cardiology will also be an important clinical area in the future. Plans are being made for laser operating rooms with multiple, readily-accessible laser systems, computer technology and in-house record systems. For laser-diagnostic areas, the examples listed in the section on laser non-surgical medicine will also be available. In the present economic period, lasers have to establish their value both for in-patient and especially for out-patient services. As indicated previously, the need of the laser in the hospital facility must be determined by community and patient needs as well as by adequate physician and paramedical training. Revolutions in laser communication and information handling will also help in the development of the deliverance of better health care. **OSMA**

The Current Laser Market (US only)

The Major Market
- Ophthalmology
- Gynecology
- Dermatology and Plastic Surgery
- Head and Neck Surgery
- Podiatry

The Minor Market
- Gastro-intestinal
- General Surgery
- Neurosurgery
- Pulmonary
- Urology
- Orthopedics
- Laser Medicine — Nephelometers
- Laser Medicine — Cell-Sorter Systems

The Future Market
- Excimer Laser Surgery
- Photodynamic Therapy for Cancer Diagnosis and Therapy
- Multiple Applications of the Free-Electron Beam Laser

Leon Goldman, MD, is sometimes referred to as the "Father of Laser Medicine." The former Cincinnati physician is now-serving as laser consultant at the U.S. Navy hospital in San Diego, California.

Next month, the Specialty Update section will return to this space with an article on "What's New in Surgery." Technology Update will be interspersed with the Specialty Update column on an irregular basis.

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Treating Your Practice—I

By the OSMA Department of Communications and Physician Marketing

Editor's note: *Last month,* OHIO Medicine *devoted feature space to the subject of Physician Marketing. This month, we continue the theme in the format of a semi-regular column. Next month, watch for "Treating Your Practice — II."*

Once you have analyzed the various aspects of your practice and pinpointed some possible weaknesses, you can begin taking some steps to strengthen those areas in need of improvement. Regardless of your particular problems, circumstances and objectives, you have three main opportunities to enhance physician-patient relationships: before, during and after their visits with you.

Drawing New Patients To Your Office

There are a wide variety of ways in which people find out you exist — and decide to pay you a visit. If you are a specialist, more than likely, many of your patients are referred to you by other physicians in your community. If you are in general practice, family practice or pediatrics, on the other hand, your patients probably found out about you through another patient. Studies show that two-thirds of all new patients pick a physician based on the recommendation of family and friends. Another third, however, discover your name through various forms of advertising and promotions: telephone book listings, mailings, brochures, referral services or even the sign you have out in front of your office.

The following are some tips for drawing more patients into your office.

Referrals

Referrals are a vital source of new patients for all physicians — whether those referrals come from other physicians, patients or other sources in the community. There are some steps you can take to increase referrals into your office.

Increasing Physician Referrals

• Make efforts to meet and socialize with more physicians. Introduce yourself at seminars, county medical society meetings, CME courses, etc. Make yourself visible in your local hospital through rounds, the cafeteria, the staff lounge, etc. Become active in organized medicine.

• Offer to conduct seminars, programs and CME courses in your specialty or some other particular area of interest. Submit articles on these subjects to your county society bulletin or to state and specialty medical journals.

• Publish a monthly newsletter on your specialty and send it to other physicians who are likely to refer patients to you. Include information about yourself and your staff, as well as the latest developments, drugs and techniques in your specialty.

• Design a brochure explaining your practice to other physicians — specialty, scope of practice, affiliation, location, hours, payment policies, etc. Send it out every time a new physician comes into town — or when someone

continued on next page



"The form of communication should be designed to communicate the information . . . in a direct, dignified and readily comprehensible manner."

new refers a patient to your office.

• Designate special hours each week for new patients who are referred to you so that you don't have to put them on a waiting list. If patients can't get in to see you for six to eight weeks, they'll probably find another physician.

• Have a private line just for physicians who want to discuss referrals with you — so that other busy practitioners aren't held up by the receptionist, put on hold, etc.

• Always report back immediately to the physician who referred the patient to you and keep him or her up-to-date on the patient's progress. Take time to communicate with the referring physician with a short note explaining the diagnosis, treatment plan, etc. Most importantly, don't forget to say "thank you" for the referral.

• Never steal patients away from a referring physician or try to take over other aspects of their health care, repeating tests and procedures. Also, never criticize the care of the physician who referred the patient to you.

Increasing Patient Referrals

• Track where your referrals are coming from through a patient questionnaire or by asking new patients to indicate on their information sheet how they found out about you.

• Thank those patients who refer other patients to your practice with a card, phone call, token gift, etc.

• Make patient information brochures available in your waiting room so that patients can take these home to friends or relatives without having to ask for them.

Other Referrals

• Encourage your local hospital or medical society to sponsor a physician referral service and to market that service to the public.

• Make patient information brochures, business cards, newsletters, etc. available at local health fairs sponsored by businesses, charitable organizations, etc.

Increasing Your Visibility in the Community

• Join civic and community groups that will help you to become an active and well-known member of your local community.

• Volunteer to promote health-related community services, such as Meals on Wheels, Transportation for Seniors, etc.

• Participate in or sponsor community health education seminars: first aid programs, child care, neo-natal care, teen babysitting, etc.

• Help with school health projects or immunization programs and health screenings.

• Sponsor school scholarships or local sports teams.

• Volunteer to be a team physician or to coach a neighborhood softball or little league team.

• Run for an elected office or volunteer to serve on a community board or commission which interests you.

• Join your local medical society's speakers' bureau. Make presentations to civic groups, parents' clubs, etc. on timely topics related to your specialty.

• Become an active member of your local Chamber of Commerce.

• Act as a volunteer consultant to local schools, nursing homes, etc.

Increasing Your Visibility Through the Media

• Watch headlines and news stories for opportunities to contribute your expert advice, opinion or assistance. The news media are always looking for physicians with some expertise in health-care areas such as AIDS or other issues in the news.

• Offer yourself as an ongoing consultant in medicine to your local newspaper, radio or TV

stations. Take advantage of the OSMA Media Training Seminars to find out how best to present your story to the media.

- Offer to be on TV or radio call-in, "Ask the Doctor" type shows.
- Volunteer to do public service announcements for your local hospital, medical society, or your favorite charitable organization.
- Find out what opportunities for local cable programming are available in your community and help sponsor and participate in a local health show.
- Volunteer to write a health column for your local newspaper or to answer readers' health questions. However, make sure you have time to undertake this project and that you are capable of making the deadlines.
- Submit articles to your local newspapers on events surrounding your practice: openings, open houses, new staff members, new equipment purchases, etc.
- Write letters to the editor of your local newspaper regarding health-care topics or other topics in the news that interest you.

Paid Promotions and Advertising

You can also increase your exposure in the media and the community through paid promotions and advertising. These can run from direct mail fliers and business cards to billboards, radio and TV advertising.

While paid media advertising has long been frowned upon by the medical community, it is becoming more accepted in certain parts of the state — particularly where competition is at its fiercest. The following general guidelines have been established for physicians wishing to advertise.

AMA Guidelines on Advertising

The American Medical Association's Judicial Council has developed the following statement regarding advertising and publicity:

"There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize himself as a physician through any commercial, publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

"The form of communication should be designed to communicate the information contained therein to the public in a direct, dignified and readily comprehensible manner. Aggressive, high pressure advertising and publicity may create unjustified medical expectations. Any advertisement or publicity, regardless of format or content, should be true and not misleading.

"The communication may include: (a) educational background of the physician; (b) the basis on which fees are determined (including charges for specific services); (c) available credit or other methods of payment; and (d) other information about the physician which a reasonable person might regard as relevant in determining whether to seek the physician's services.

"Testimonials of patients, however, as to the physician's skill or the quality of his professional services should not be publicized. Statements relating to the quality of medical services are extremely difficult, if not impossible, to verify or measure by objective standards. Claims regarding experience, competence and the quality of the physician's services may be made if they can be factually supported and if they do not imply that he has an exclusive and unique skill or remedy. A statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment may imply a certainty of result and create unjustified and misleading expectations in prospective patients.

"Consistent with Federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio or television, should determine in advance that his communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered.

"As used herein, references to a 'physician' apply also to information relating to the physician's group, partners or associates. Any communication or message within the scope of this opinion should include the name of at least one physician responsible for its content.

"Nothing in any opinion of the Judicial Council is intended or shall be construed to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. (II)"

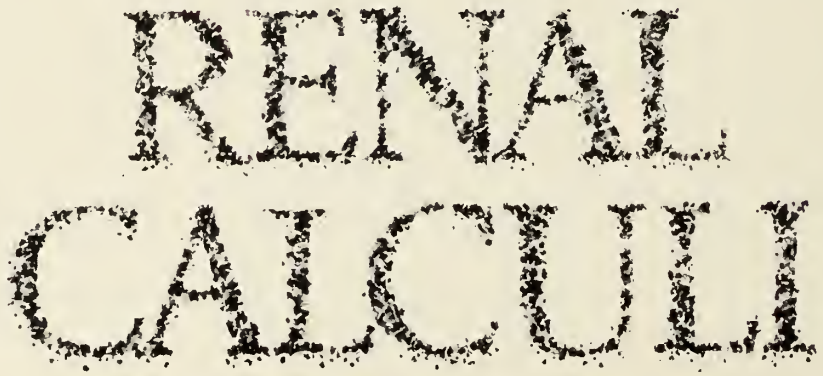
OSMA Resolution on Advertising

While the Ohio State Medical Association has no formal policy on advertising, a resolution passed by the 1987 OSMA House of Delegates reads as follows:

"RESOLVED, That the OSMA encourage its members who wish to market their services to adopt marketing practices:

1. which are not false,

IMAGINE A MACHINE THAT CAN DO THIS TO



We're proud to announce the introduction of Extracorporeal Shock Wave Lithotripsy as a new feature of our kidney stone treatment program. This new device makes it possible to pulverize and eliminate kidney stones without invasive surgery. Now you have the opportunity to participate in this state-of-the-art procedure at CAMC's High Tech Center here in Charleston, West Virginia.

The Lithotripter uses shock waves to bombard kidney stones into sand-like particles inside the body. The residue is then easily passed. Although the theory behind Lithotripsy is simple, the process is precise. The stone is pinpointed inside the body with fluoroscopy and shock wave firing is synchronized with the patient's heartbeat by electrocardiogram. Usually, the entire process takes about an hour.

As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

We're encouraging all area urologists to apply for privileges in Extracorporeal Shock Wave Lithotripsy. We invite you to visit CAMC and see the lithotripter in action. Come and learn about this revolutionary therapy. We will happily provide you with a brochure for your use as well as brochures for your patients.

For your brochures or other information about Lithotripsy and our kidney stone treatment program, call CAMC: in West Virginia at 1-800-654-0159; from out of state, call 304-340-7315.

CAMC
Charleston Area Medical Center
We Care For West Virginia

fraudulent, deceptive or misleading; and

2. which are designed to give the public adequate information regarding the nature and scope of the various medical specialties to permit individuals to make informed choices regarding their selection of physicians . . ."

Local Protocol on Advertising

Because the amount of paid advertising by physicians varies greatly from community to community, you may want to gauge your own advertising budget by the amount being done by doctors in your area.

For example, if most physicians limit their paid promotions to business cards, patient newsletters and yellow pages advertising, you may be criticized if you step too far beyond those areas. If, however, physician groups in your area advertise in the newspaper, use billboards and spot radio announcements, you may want to consider doing the same in order to get noticed.

Tips on Paid Promotions and Advertising

• Telephone Book Advertising has long been a necessary source of putting your name before the public. Investigate the various alternatives available for advertising in the white and yellow pages of your local directory.

• Take advantage of "good will" ads — those advertisements sold in school sports and graduation programs, church bulletins, yearbooks, civic directories, local community theater playbills, etc.

• Develop a patient newsletter of your own or purchase one which allows your name and telephone number to be printed at the top, such as the OSMA *Health Hints.*

• Budget carefully for any type of media advertising. It can be expensive, and in most instances, repeated exposures will be necessary to get your message across. A one-time newspaper ad or radio spot rarely brings a noteworthy response.

• Keep newspaper ads simple, informational and professional in appearance. Make sure they include your logo, name, address and a map of your location if you are difficult to find.

• If you wish to advertise on TV or the radio (fewer than 5% of all physicians use these expensive media), use professionals to develop and execute your ad — in order to retain a professional image and appearance.

The Telephone Book

Physicians' names and telephone numbers have been listed in the phone book for as long as such books have existed. More recently, a number of practices have taken advantage of the yellow pages to list anything from the physician's name to details about location, hours and specialty.

Likewise, patients frequently turn to the telephone book for the names of physicians in their areas. Among those who "let their fingers do the walking" are patients new to the community, those dissatisfied with their current physician or the many individuals who do not have a regular personal doctor.

As with any advertising, the key to effective yellow page advertising is that the ad be simple, clear and professional. Typefaces used should be uniform and artwork should be neat and up-to-date and can include your logo or some other symbol, a sketch of your building or a map indicating your location. Most boxed display ads are at least two columns in width and include hours, location, the names of physicians in the practice and specialty.

The main purpose of the display ad is to get new patients to call your practice. However, if you are a specialist who operates chiefly by referral, a simple alphabetical listing may be adequate.

You can gain more attention by:



Gauge your ad budget by the amount being done by others . . .

• Having your name or the practice name run in bold type.

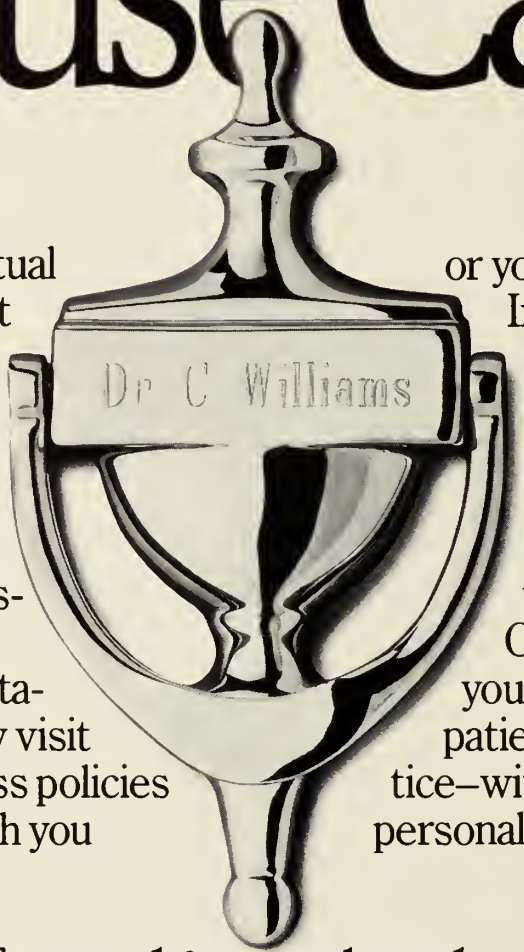
• Adding one or two extra lines of type under your name with your practice name or your hours.

• Listing your name in several locations: for example, under the physician's name, under the practice name or under the specialty listing.

In addition to the standard telephone book, some private companies sponsor community telephone directories or business directories that will include your name and telephone number for a small fee. Your local Chamber of Commerce will probably be able to provide you with the names of alternative phone directories.

One thing to note is that regular telephone directory advertising tends to be very expensive. However, considering the amount of use the telephone book gets — and the fact that your ad is readily available to everyone for an entire year, it can be a good buy for the money. **OSMA**

We Still Make House Calls.



Community Mutual feels the best, most up-to-date service isn't *always* at the other end of a phone line. That's why, at your request, our Professional & Provider Relations representatives will personally visit your office to discuss policies and procedures with you or your office staff. If you prefer calling us, we do our best to answer your question or solve your problem in that first single telephone call. Our goal is to help you provide all of your patients–and your practice–with the very best of personalized service.

Professional & Provider Relations– Your Partners In Service

For medical claims or payment questions, call 1-800-282-1016.
For dental claims or payment questions, call 1-800-282-1730.
For information on policies or procedures, contact our representative in your area:

Canton Area	*Cleveland Area*	*Dayton Area*	*Toledo Area*
(216) 492-2151	*(216) 642-0955*	*(513) 228-8710*	*(419) 249-7400*
Cincinnati Area	*Columbus Area*	*Lima Area*	*Youngstown Area*
(513) 872-8381	*(614) 433-8686*	*(419) 228-3457*	*(216) 783-9800*

COMMUNITY MUTUAL

Blue Cross® Blue Shield®

Ask us about Community Preferred, the new benefits option Ohio employers have been asking for.

® *Registered Marks Blue Cross and Blue Shield Association.*

Infectious Diseases in Child Day Care: Management and Prevention.

By Michael T. Osterholm, Jerome O. Klein, Susan S. Aronson, Larry K. Pickering; The University of Chicago Press; 175 Pages; $30.00

Infectious Diseases in Child Day Care: Management and Prevention presents the papers delivered at a symposium of the same name held in Minneapolis on June 21-23, 1984. The editors note that the purpose of this meeting was to summarize the knowledge regarding transmission and prevention of infectious diseases in day care centers, to stimulate exchange of this information and to develop recommendations for further action. Their book contains the proceedings of this meeting in journal article format.

The works of the individual authors are organized in six sections. The Overview contains a paper paralleling issues of psychological and physical health in day care settings and a discussion by Dr. Klein of some key infectious disease issues.

The second section contains presentations of the clinical and epidemiological aspects of certain diseases in this setting. Topics covered include: otitis media, respiratory tract infections, acute diarrhea, hepatitis, H. flu. infections, vaccine-preventable diseases, varicella, cytomegalovirus, and human T-lymphotropic virus type III. Section three discusses prevention policies and practices including disease surveillance, day care design, care of the acutely ill child and the role of the infectious disease specialist. The fourth section addresses the issue of regulation and that of liability.

A potpourri of items including training for personnel, drug administration, health benefits of day care attendance, day care homes, and the relationship between day care and health-care providers is found in section five. Section six is a summary of the symposium and its recommendations.

The credentials of the editors are impeccable and most of the contributors are renowned in their fields. The papers are well researched, although in this relatively young field, some of the information (researched in 1984) is already dated.

The journal article style makes reading this book from cover-to-cover a relatively tedious chore and multiple writing styles add to this problem. Imbedded within these pages, however, is much valuable information of practical importance to the clinician. This book would be a welcome addition to any reference library collection and would be useful on the office shelf of the primary health-care provider who must make frequent clinical decisions involving day care attendees.

— **John B. Chessare, MD**
Department of Pediatrics
Toledo

The credentials of the editors are impeccable . . . the papers are well researched, although, in this relatively young field, some of the information is already dated . . .

How More Than 3000 Doctors Have Eased The Pain Of Managing A Practice.



If your practice is like a lot of others, you often spend more time on office problems than on the health problems of your patients.

Our one easy-to-use, fully-integrated computer system can take care of billing, provide financial updates, help you market your practice. And give you more time to do what you went to medical school for.

"We've found that Medic saves us many hours of paperwork every week."
John Hollon, M.D., Main Medical Inc., Wilmington, Ohio

With Medic, jobs that once took a large part of the business day can be done in minutes. And that's only one of the ways that Medic makes the medical office run more smoothly.

"It's helped our cash flow tremendously."
Mike Griga, general manager of Mayfield Neurological Institute, Cincinnati, Ohio

Changing the billing system from once a month to once a week is just one way Medic has improved the bottom line of the nation's largest neurosurgery group. The Medic system can ease the process of sending statements and reduce the number of uncollected bills. Plus, our easy-to-understand printouts help you keep better track of your financial condition.

"Our practice has doubled and we have not had to add additional billing personnel. Medic has been able to handle whatever we've asked of it."
Nancy Psimas, office coordinator, Portsmouth Orthopaedic Associates, Portsmouth, Virginia

We'll do whatever it takes to keep your system working. Day or night. We have a toll-free STAT line to handle questions and problems. And there's a STAT PLUS line from our support center to your system for software updates and diagnoses.

"Their software updates are timely and they've gone out of their way to add programs to meet our needs."
Richard I. Tapper, M.D., Toledo, Ohio

Not only do we make program changes for individual medical practices, we also provide our customers with software enhancements, which often result from customer suggestions.

"Medic's extensive training program for our staff made it easy to introduce the system. We recommend it highly."
Tessa Horne, administrator, Morgantown Ear, Nose & Throat Clinic, Morgantown, West Virginia

"We love the training program. And the updates they do really help," Ms. Horne said. When a practice brings in over 200 patients a day as this one does, the business office has to run smoothly. "Medic does everything we need. It's great."

So if you want to increase the efficiency, productivity and profitability of your practice, take a look at the Medic Computer System.

Over 3000 physicians in more than 800 practices throughout the U.S. are calling it a minor medical miracle.

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computer systems

8601 Six Forks Rd., Ste. 300, Raleigh, NC 27615
Ph. 919-847-8102. In NC Call: 1-800-822-2914
In Western US Call: 1-800-541-7717
In Eastern US Call: 1-800-334-8534

Other Offices: Orlando, Ann Arbor, Chicago, Cincinnati, Pittsburgh, Richmond, Atlanta

It's Time for 1988 Membership Renewal

By Katherine E. Wisse

December 31 is the deadline for renewing your county society, Ohio State Medical Association and American Medical Association dues for 1988.

Your membership in the local medical society, the OSMA and the AMA affirms your support of organized medicine and its influence on the practice of medicine. As a physician in Ohio, many of the actions taken by the OSMA, in conjunction with your county society, will have a positive effect on your livelihood — today and for years to come.

As a member, you are entitled to take advantage of many benefits offered by the OSMA. Each month you will receive *OHIO Medicine, OSMAgram,* the *Legislative Bulletin,* publications designed for patient information, etc. You will be eligible for group term life and health insurance as well as liability insurance offered by Physicians Insurance Company of Ohio (PICO).

In addition, you will be represented in the state legislature. Your views will be presented to the public and the media, and you can enhance your practice with continuing medical education courses, the services of the OSMA ombudsman, practice management and patient relation services.

This year the physicians' information hotline (1-800-346-OSMA) is available for your use to learn developments in the courts and legislature, both state and national; OSMA and AMA's position on legislative issues; OSMA and AMA scheduled meetings, etc.

The OSMA currently offers a dues exemption to retired or disabled members. A member qualifies if he is fully retired from the practice of medicine. There is no dues exemption based on age.

The physicians' information hotline is available for your use to learn developments in the legislature

If you are eligible, notify the OSMA and your county secretary/treasurer.

The AMA currently offers reduced dues to semi-retired or retired members on the following basis:

Age 70, working 1-20 hours per week	$187.00
Fully retired, under age 70:	$ 75.00
Fully retired, over age 70	No dues

Fully retired AMA members will receive a free subscription to the *American Medical News. JAMA* and other AMA journals will be available to them at 50% off the regular subscription price.

If you have been exempt from AMA dues prior to 1987 this exemption will continue. If you have any questions about your AMA retired status call the AMA direct (Margaret Jordan, 312-645-4784).

If you are a non-resident or leave Ohio, you can keep in touch with your Ohio colleagues and OSMA activities as a non-resident member with annual dues of $40.00.

For further membership information please contact Katherine E. Wisse, Director of Membership Development (614) 228-6971.

Remember these are just a few OSMA membership benefits:

OHIO Medicine
Legal services
OSMAgram
Legislative Bulletin
Ombudsman program
Contract analysis service
Physicians' information hotline
Continuing Medical Education
Legislative representation
Practice management seminars
Patient relations **OSMA**

Katherine Wisse is Director of the Department of Membership Development.

OBITUARIES

LUIS ALARCOM, MD, Lorain; Facultad de Medicina de San Fernando de la Universidad Nacional Mayor de San Marcos, Lima, Peru, 1956; age 60; died September 24, 1987; member OSMA.

HUBERT S. BANNINGA, MD, Youngstown; University of Michigan Medical School, Ann Arbor, MI, 1928; age 83; died September 17, 1987; member OSMA and AMA.

RICHARD BELCHER, MD, Canton; Ohio State University College of Medicine, 1962; age 50; died September 17, 1987; member OSMA and AMA.

LESLIE J. BOONE, MD, Waverly; Temple University School of Medicine, Philadelphia, PA, 1933; age 81; died September 21, 1987; member OSMA and AMA.

LARRY W. BUCKLEY, DO, Akron; Kirksville College of Osteopathic Medicine, Kirksville, MO, 1979; age 43; died August 3, 1987; member OSMA and AMA.

EARL J. LEVINE, MD, Wellston; University of Virginia School of Medicine, Charlottesville, VA, 1943; age 68; died August 27, 1987; member OSMA.

JAMES C. OBERHOLTZ, MD, Akron; Hahnemann Medical College of Philadelphia, Philadelphia, PA, 1952; age 66; died July 29, 1987; member OSMA.

ROBERT E. PUMPHREY, MD, Naples, FL; Ohio State University College of Medicine, 1930; age 81; died August 26, 1987; member OSMA and AMA.

FRED L. SCHELLHASE, MD, Youngstown; Ohio State University College of Medicine, 1941; age 70; died June 21, 1987; member OSMA and AMA.

JACK N. TAYLOR, MD, Columbus; Harvard Medical School, Boston, MA, 1943; age 69; died September 7, 1987; member OSMA and AMA.

CARL E. ZEITHAMI, MD, Cleveland; Case Western Reserve University School of Medicine, 1930; age 81; died September 4, 1987; member OSMA and AMA.

continued on page 882

NEW MEMBERS

ATHENS
Pakkirisamy Shanmugam, MD, Athens

BELMONT
Phillip J. Murray, MD, St. Clairsville

CUYAHOGA
(Cleveland unless noted)
John M. Dobrowski, MD
David Feiner, MD, East Lansing
Mark Le Vine, MD
Mark Rosenfeld, MD, Shaker Heights
William E. Rush, MD
Pankaj D. Shah, MD, Westlake
Ildiko G. Varga, MD

FRANKLIN
(Columbus unless noted)
Lawrence M. Agius, MD
Frank Birinyi, MD
Charles D. Cammock, MD
Jeffrey L. Childes, MD
Antonios Emanuel Chryssos, MD
Robert J. Derick, MD
Jose A. Duarte, MD, Worthington
Steven C. Gentile, MD
Vatche A. Israbian, MD
Eric E. Jones, MD
Vincent M. Koike, MD
Robert F. Lewe, MD
Pamela V. Lois, MD, London
Richard Alan Martin, MD
Isaac M. Minehart, MD
Harvey L. Mirly, MD
Vicki M. Morris, MD
James L. Murphy, Jr., MD
Douglas P. Myers, MD
John Neff, MD
Michael G. Nunley, MD
Gregory D. Rypel, MD, Westerville
Philip A. Scalamogna, MD
Jeffery D. Sellers, MD, Dublin
Daniel M. Waller, MD, Worthington
Jordan Spence Zuckerman, MD

HAMILTON
(Cincinnati unless noted)
Rekha H. Buddhdev, MD
Camille Crawford, MD
Samia I. Eid, MD
Mark C. Johnson, MD
Sudha A. Mehta, MD
John M. Ryan, MD

HARRISON
R.C. Rubiano, MD, Cadiz

HURON
James R. Hays, MD, Bellevue

JEFFERSON
Marjorie L. Bush, MD, Wheeling

LUCAS
Karl J. Beer, MD, Oregon
Jean A. Chapman, MD, Toledo
Thomas H. Corbett, MD, Sylvania

MAHONING
Violet C. Nagina, MD, Youngstown

MUSKINGUM
Dinker Trivedi, MD, Zanesville

WASHINGTON
Warren L. Cooper, Jr., MD, Marietta

WILLIAMS
James L. Derickson, MD, Bryan

Report on Examination of Financial Statements for the years ended December 31, 1986 and 1985

Report of Independent Accountants

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheets of Ohio State Medical Association at December 31, 1986 and 1985 and the related statements of operations and undesignated net worth and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of Ohio State Medical Association at December 31, 1986 and 1985 and the results of its operations and changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Columbus, Ohio
May 1, 1987

Ohio State Medical Association
Balance Sheet, December 31, 1986 and 1985

ASSETS	1986	1985
Current assets:		
Undesignated cash and cash equivalents	$1,894,769	$ 851,802
Marketable securities (fair market value of $1,017,835 and $1,257,964) (Note 1)	983,644	1,256,778
Accounts receivable	76,571	71,055
Accounts receivable, PICO	72,589	12,470
Accrued interest receivable	43,296	26,473
Prepaid expenses	38,435	47,503
Total current assets	3,109,304	2,266,081
Other assets:		
Funds restricted for designated purposes (Note 2)	761,681	651,392
General Trust Fund, at approximate market	47,272	65,810
Notes receivable	154,759	136,207
Investments:		
Physicians Insurance Company of Ohio (PICO), at cost (Notes 3, 4, and 7)	100,000	100,000
622 South High Street, Inc. (Note 5)	22,302	23,459
Real estate (building — $2,090,000; equipment — $260,000; net of accumulated depreciation of $352,125 in 1986 and $273,875 in 1985) (Note 7)	1,997,875	2,076,125
IONA, Inc., at cost	25,000	25,000
	3,108,889	3,077,993
Property and equipment, at cost (Notes 1 and 6):		
Building	572,481	572,481
Data processing equipment	195,323	188,668
Furniture, fixtures and equipment	115,610	121,022
	883,414	882,171
Less accumulated depreciation	(408,495)	(357,844)
	474,919	524,327
Land	448,628	448,628
	923,547	972,955
	$7,141,740	$6,317,029

The accompanying notes are an integral part of the financial statements.

Liabilities and Net Worth

	1986	1985
Current liabilities:		
Accounts payable	$ 255,617	$ 275,703
Accounts payable, PICO (Note 3)	5,478	5,478
Current portion, term debt (Note 6)	15,481	13,544
Dues collected in advance for related societies in the federation	928,231	661,082
Accrued pension expense	124,823	121,522
Total current liabilities	1,329,630	1,077,329
Term debt (Note 6)	2,443,190	2,458,670
Deferred income:		
Annual membership dues (Note 1)	949,012	676,275
Life membership dues (Note 1)	27,000	29,050
Other		2,871
	976,012	708,196
Commitments and contingencies (Note 5)		
Net worth (Note 2):		
Designated funds	916,008	651,392
Undesignated funds	1,476,900	1,421,442
Total net worth	2,392,908	2,072,834
	$7,141,740	$6,317,029

The accompanying notes are an integral part of the financial statements.

Statement of Operations and Undesignated Net Worth for the years ended December 31, 1986 and 1985

	1986	1985
Income:		
Membership dues (Notes 1, 3 and 10)	$3,330,679	$3,040,943
Exhibit fees	7,200	12,900
Annual meeting	17,020	19,330
Fees for collection of AMA dues	8,825	14,183
CME accreditation and courses	9,534	1,560
Ohio State Medical Journal (Note 10)	174,356	191,953
Interest	342,016	379,683
General trust expense, net	(18,538)	(21,912)
Administration and technical service (Note 3)		70,000
Rental income	3,900	9,429
Services to specialty societies	82,469	73,606
Insurance rate credit (Note 3)		148,685
Other, net	108,825	146,469
	4,066,286	4,086,829
Departmental operating expenses:		
Administration	647,712	504,387
Education, specialty societies and meeting management	573,224	580,386
Health education	127,972	121,840
Fiscal and membership	503,889	449,656
Government relations	265,377	233,651
Communications	722,329	771,885
Development and member services	323,506	223,980
State legislation	312,107	270,588
Legal services	214,028	222,802
	3,690,144	3,379,175
Income from operations before loss from lease to related party and equity in losses of subsidiaries	376,142	707,654
Loss from lease to PICO (Note 7)	(54,911)	(52,972)
Equity in loss of 622 South High Street, Inc. (Note 4)	(1,157)	(938)
Income from continuing operations before income taxes	320,074	653,744
Provision for income taxes on unrelated business taxable income		10,500
Income from continuing operations	320,074	643,244
Equity in loss of discontinued subsidiary (PACO), less applicable income tax benefit of $10,500 (Note 5)		(138,976)
Net income	320,074	504,268
Undesignated net worth, beginning of year	1,421,442	1,026,290
Transfer to designated funds, net (Note 2)	(264,616)	(109,116)
Undesignated net worth, end of year	$1,476,900	$1,421,442

The accompanying notes are an integral part of the financial statements.

Statement of Changes in Financial Position for the years ended December 31, 1986 and 1985

	1986	1985
Cash provided from (used for) current operations:		
Net income	$ 320,074	$ 504,268
Add charges not involving cash:		
Depreciation and amortization	141,389	140,346
Equity in losses of subsidiaries	1,157	139,914
Provision for income taxes		10,500
	462,620	795,028
Increase in accounts receivable	(65,635)	(4,029)

Increase in accrued interest receivable	(16,823)	(26,473)
Decrease in prepaid expenses	9,068	5,259
Increase (decrease) in accounts payable	(33,050)	39,747
Increase in dues collected in advance for related societies in the federation	267,149	488,565
Increase in accrued pension expense	3,301	388
Increase in deferred income	280,780	114,314
Cash provided from current operations	907,410	1,412,799
Cash used for financing activities:		
Repayment of term debt	(13,543)	(14,708)
Cash provided from (used for) investment activities:		
Increase in funds restricted for designated purposes	(110,289)	(109,116)
Decrease in General Trust Fund	18,538	21,912
(Increase) decrease in notes receivable	(18,552)	(9,335)
Amounts advanced to PACO		(149,476)
Liquidation of investment in PRORECO		25,000
Additions to property and equipment, net	(13,731)	(18,248)
Cash used for investment activities	(124,034)	(220,593)
Increase in undesignated cash, cash equivalents and marketable securities	769,833	1,177,498
Undesignated cash, cash equivalents and marketable securities:		
Beginning of year	2,108,580	931,082
End of year	$2,878,413	$2,108,580

The accompanying notes are an integral part of the financial statements.

Notes to the Financial Statements

1. **Accounting Policies:**
The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.
   a. **Marketable Securities:**
   Marketable securities consist of United States Treasury notes and Federal Home Loan Bank bonds and are recorded at the lower of aggregate cost or market.
   b. **Depreciation:**
   The Association recognizes depreciation and amortization on the straight-line method in amounts adequate to amortize costs over the estimated useful lives of the assets as follows:
   Building and improvements .....10-40 years
   Data processing equipment .....5 years
   Furniture, fixtures and equipment .....10 years
   Depreciation and amortization charged to operations were $141,389 in 1986 and $140,346 in 1985, including depreciation on a building leased to PICO (Note 7). Disposals of fixed assets are accounted for as reductions to cost and accumulated depreciation. Any resulting gain or loss is credited or charged to other income.
   c. **Deferred Membership Dues:**
   Income from annual membership dues is recognized in the calendar year to which the dues apply. Life membership dues income is recognized over an estimated 25 years of active practice of the life membership participants.
   d. **Exemption — Federal Taxes on Income:**
   The Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code. The provision for income taxes included in the 1985 statement of operations and undesignated net worth represents federal income taxes on net unrelated business taxable income for financial purposes.
   e. **Reclassifications:**
   Certain amounts in the 1985 financial statements have been reclassified to conform to the current year presentation.

2. **Funds Restricted for Designated Purposes:**
During 1986 and 1985, the Council of the Ohio State Medical Association authorized funds to be restricted for designated purposes. The funds represent cash and cash equivalents that have been designated for the following purposes as of December 31:

	1986	1985
Capital Asset Improvements and Replacement	$268,233	$178,059
Data Processing Improvements and Replacement	380,132	316,439
Malpractice Research	9,423	60,943
Staff Development	103,893	95,951
	$761,681	$651,392

3. **Physicians Insurance Company of Ohio and Subsidiaries:**
The Association owns 100% of the Class B common stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each class of stock has equal rights on a per share basis to participate in dividends and other types of distributions. The Association earned $7,800 of dividend income in 1985, which is included in other income in the accompanying financial statements. Each Class A share is entitled to one vote, and each Class B share is entitled to 100 votes.
By virtue of its ownership of 100% of the outstanding Class B shares (36,000 shares), the Association is entitled to 3,600,000 votes. At December 31, 1986, the Class A shareholders owned 3,043,542 shares of Class A stock. Accordingly, at December 31, 1986, the Association was entitled to exercise 54.19% of the voting power of PICO. If the total authorized Class A shares (8,000,000) and Class B shares (66,668) were to be sold, the Class B shareholders would hold approximately 45% of the voting control over PICO.
The Association has recorded its investment in PICO at cost instead of under the equity method since, although owning a controlling interest in PICO, the Association does not share significantly in PICO's earnings.
PICO is limited to selling medical liability insurance only to members of the Association. PICO wishes to encourage medical students to join the Association, hopefully leading to future insurance business for PICO. As a result the Association and PICO entered into an agreement whereby PICO agreed to reimburse the Association for direct and indirect costs of promoting organized medicine, including the promotion and servicing of new student and resident memberships in the Association. Total reimburse-

ment for the national, state and county medical society membership dues of medical students and residents, including reimbursement for costs incurred in promoting and servicing the student and resident memberships, was $448,527 in 1986 and $400,000 in 1985. OSMA's portion of such reimbursements was $217,500 and $204,800 in 1986 and 1985, respectively, and is included in membership dues income in the statement of operations and undesignated net worth.

In connection with a group professional liability insurance plan, OSMA earns interest income on premium payments from its member physicians.

American Physicians' Life Insurance Company (APL), a subsidiary of PICO, paid the OSMA $70,000 in 1985, to defray other clerical and administrative expenses incurred by the Association on behalf of APL. These funds are classified as administrative and technical service income in the statement of operations and undesignated net worth.

In 1985, APL paid OSMA an experience rate credit of $148,685 and interest of $101,315 in connection with a group term life insurance policy offered by APL through OSMA to its members. The credit relates to the better-than-expected loss rate experienced by APL over the seven years of the policy's existence and is included in the statement of operations and undesignated net worth.

Pursuant to a settlement agreement between the Ohio Department of Insurance and PICO, the OSMA was required to reject and refuse to accept the unilateral assignment (totaling approximately $2,000,000), dated December 13, 1983, by PICO of a portion of its investment income from Fireman's Fund Insurance Company. Since no income was ever recorded due to contingencies in the original unilateral assignment and no income was or will be realized, the transaction is void from the beginning.

4. **Investment in 622 South High Street, Inc.:**

During 1981, OSMA formed a corporation known as 622 South High Street, Inc. (622), having as its main purpose the ownership and management of property at 622 South High Street, Columbus, Ohio. In exchange for property which at December 31, 1980 had a book value of $85,000, the Association received 100% ownership in said corporation (100 shares of common stock at $255 a share) for $25,500 and a 10% mortgage note receivable for $59,500, maturing in 2029, payable in equal monthly installments of $500. During 1983, the building at 622 South High Street was demolished to make way for future expansion, ending 622's receipt of rental income and ability to pay mortgage payments to the Association. A payment made by OSMA of $6,800 for demolition work was accounted for as an additional investment. At December 31, 1986 and 1985, the note receivable had a book value of $60,842.

OSMA accounts for the investment using the equity method, and the investment account reflects the following activity for the years ended December 31:

	1986	1985
Investment in 622, beginning of year	$23,459	$24,397
Net loss	(1,157)	(938)
Investment in 622, end of year	$22,302	$23,459

Condensed financial information for 622 South High Street, Inc. is as follows:

Condensed Balance Sheet

	December 31 1986	1985
Assets	$84,486	$84,651
Liabilities	62,184	61,192
Net worth	$22,302	$23,459

5. **Physicians Administrative Corporation of Ohio:**

During 1982, OSMA formed a corporation known as Physicians Administrative Corporation of Ohio (PACO) whose main purpose was to sell computer systems and the related software to physicians for use in their practices and to provide services to physicians relating to processing third party billings.

The Association owns 100% of the corporation and initially funded the Company with capitalization of $285,000 and software which had a book value of $15,000. In addition, the Association guaranteed a line of credit for PACO of $300,000. On December 31, 1984, PACO signed a note payable to OSMA in the amount of $269,252, due March 31, 1985, with interest at 10%. For accounting purposes the note has been written off due to PACO's inability to repay.

On August 24, 1985 PACO terminated all but three of its employees and subsequently vacated its leased office space. PACO's activities were terminated on December 31, 1985, and no further investments or advances were made to PACO.

On August 14, 1986 the software was sold for $300,000 in cash. Proceeds from the sale were used to repay the bank debts in the amount of $300,000.

Condensed financial information for PACO is as follows:

Condensed Balance Sheet

	December 31, 1986	1985
Assets	$ 34,230	$ 308,657
Liabilities	497,622	957,952
Shareholder's deficit	$463,392	$ 649,295

Condensed Statement of Operations

	Years Ended December 31, 1986	1985
Income	$354,125	$ 459,708
Expenses	168,223	943,844
Net income (loss)	$185,902	$(484,136)

OSMA accounts for the investment using the equity method. The investment account reflects the following activity during the year ended December 31, 1985:

Investment in, and advances to, PACO, beginning of year	$ —0—
Advances to PACO	149,476
Loss before applicable income tax benefit relating to OSMA's investment and advances	($149,476)
Investment in, and advances to, PACO, end of year	$ —0—

Through December 31, 1985 OSMA made investments in and advances to PACO totaling $718,728, all of which has been recognized as losses either through PACO operating loss or reserve against outstanding advances (notes receivable). No additional investments or advances were appropriated during 1986.

6. **Term Debt:**

Term debt at December 31, 1986 consisted of the following:

14.5% Mortgage loan payable in annual installments of $361,472, including interest, beginning December 1, 1983, collateralized by the assignment of rents

and security deposits from PICO (see Note 7) and due December 1, 1989	$2,389,462
8% Mortgage loan payable in monthly installments of $500, including interest computed semiannually, collateralized by land and building. OSMA has the right of prepayment	69,209
	2,458,671
Less current portion	15,481
	$2,443,190

After December 1, 1987, the bank has the right to declare all unpaid principal and interest payable, and OSMA has an unlimited right of prepayment on the 14.5% mortgage loan payable. As described in Note 7, the Association has the right to require prepayment of all rent after January 15, 1988. Accordingly, the debt has been classified as noncurrent.

Maturities on term debt subject to mandatory redemption are as follows:

1987	$ 15,481
1988	17,696
1989	20,229
1990	23,128
1991	26,443
Later years	2,355,694
	$2,458,671

7. **Leases:**

The Association leases office facilities and equipment with a net book value of $1,997,875 to PICO, a related party (Note 3), under terms of an operating lease. The office facility lease term expires January 15, 1995, with monthly rent of $26,875. The equipment lease term expires January 15, 1993, with monthly rent of $3,600. PICO has the option to purchase the office facility and equipment at the end of the lease term for $2,155,000 and $50,000, respectively. The Association has the right to require prepayment of all rent at any time after January 15, 1988. Should OSMA exercise this option, PICO may purchase the facility and equipment at a price set forth in the lease agreement. PICO pledged bonds with a par value of $2,500,000 as security for the lease payments.

Future minimum rentals to be received from the above operating lease as of December 31, 1986 are as follows:

1987	$ 365,700
1988	365,700
1989	365,700
1990	365,700
1991	365,700
Later years	1,010,700
	$2,839,200

The Association leases the land on which the above facility is located from PICO under terms of an operating lease. The lease term expires January 15, 2023 with monthly payments of $400. PICO has the option to terminate the lease in the event the above described option to purchase the facility from OSMA is exercised.

The following is a summary of the activity related to the above transactions for the years ended December 31:

	1986	1985
Rental income	$365,700	$365,700
Interest income	10,810	14,396
	376,510	380,096
Expenses:		
Rent	4,800	4,800
Interest (Note 6)	348,371	350,018
Depreciation	78,250	78,250
	431,421	433,068
Net loss	$ 54,911	$ 52,972

Additionally, OSMA leases automobiles and certain office equipment for terms of up to five years. Minimum annual rental commitments under noncancelable operating leases as of December 31, 1986 are as follows:

1987	$ 87,627
1988	79,181
1989	64,357
1990	45,239
1991	4,800
Later years	148,800
	$430,004

Rental expense for 1986 and 1985 was $127,318 and $100,516, respectively.

8. **Pension Plan:**

The Association maintains a trusteed noncontributory defined benefit pension plan for its eligible employees. The actuarial cost method used in determining the valuation of funding is the entry-age-normal with frozen-initial-liability method. The trustee of the Plan is American Physicians Life Insurance Company, a subsidiary of PICO and a related party to OSMA.

The total cost of the plan charged to operations in 1986 and 1985 was $109,720 and $110,910, respectively, which includes amortization of past service costs over approximately a thirty-year period.

A comparison of the accumulated benefits and net.assets for the plan years beginning December 31, is as follows:

	1986	1985
Actuarial present value of accumulated plan benefits:		
Vested	$1,019,691	$ 895,400
Nonvested	81,884	81,497
Total	$1,101,575	$ 976,897
Market value of plan assets available for benefits	$1,465,747	$1,243,640

The assumed investment rate of return used in determining the actuarial present value of accumulated plan benefits was 8.0%.

9. **Postretirement Benefits:**

In addition to providing pension benefits, the Association provides certain health-care benefits for retired employees. All of the Association's employees may become eligible for those benefits if they reach normal retirement age while still working for the Association. The Association recognizes the cost of providing those benefits by expensing the insurance premiums which were $12,433 and $11,331 for 1986 and 1985, respectively.

10. **Ohio State Medical Journal:**

The income and expenses applicable to the operations of "Ohio State Medical Journal," for the year ended December 31, 1986, are:

Income:	
Advertising (net of commissions and cash discounts of $47,566)	$168,730
Membership subscriptions, allocated at $15 per dues-paying member (included in membership dues	

Financial Statement . . . *continued*

income on the Statement of Operations and Undesignated Net Worth)	298,335
Outside subscriptions and other income	5,626
	472,691
Expenses:	
Salaries, pension costs, payroll taxes and other employee benefits	105,721
Printing, postage, stationery, supplies, illustrations, engravings and consulting services	213,181
Building expenses, depreciation and other	95,994
	414,896
Excess of income over expenses, Ohio State Medical Journal	$ 57,795

AIDS Guidelines...*continued*

Inactivation of a new retrovirus (lymphadenopathy-associated virus) by various agents (chemical disinfectants). Lancet 1984:8408; 899-901.

5. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
6. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983;32:101-4.
7. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.
8. CDC. Update: prospective evaluation of health-care workers exposed via parenteral or mucousmembrane route to blood or body fluids from patients with acquired immunodeficiency syndrome. MMWR 1985;34:101-3.
9. CED. Hepatitis B vaccine: evidence confirming lack of AIDS transmission. MMWR 1984;33:685-7.

OBITUARIES

continued

ROBERT L. GRAHAM, MD, Canton; University of Rochester School of Medicine, Rochester, NY, 1938; age 74; died October 5, 1987; member OSMA and AMA.

RALPH MINGES, MD, Cincinnati; University of Louisville School of Medicine, Louisville, KY, 1946; age 66; died September 3, 1987; member OSMA.

ARMANDO T. OCHOA, MD, Cleveland; Faculty of Medicine & Surgery, University of Santo Tomas, Manila, Philippines, 1962; age 53; died August 8, 1987; member OSMA and AMA.

LLOYD M. SNIVELY, MD, Massillon; Case Western Reserve University School of Medicine, 1932; age 80; died September 20, 1987; member OSMA and AMA.

LEE C. UNDERWOOD, MD, Canton; Case Western Reserve University School of Medicine, 1942; age 74; died September 16, 1987; member OSMA and AMA.

Ask the Ombudsman

Q. *Currently, Medicare will not pay for another physician who assists in surgery in a teaching hospital. The hospital does not always have resident physicians available, and a staff physician is called to assist. I cannot continue to perform assistant surgery for nothing. Can anything be done?*
MD, Columbus

A. Effective October 1, 1982, Medicare does not reimburse assistants at surgery if a hospital has a residency program related to the surgical specialty involved, or a general surgical residency. Payment by Medicare is available if:

1) The surgery was too complex to allow utilization of a *general surgery* resident and a resident in the required surgical specialty was not available;
2) Exceptional medical circumstances existed, i.e., emergency life-threatening situations, high-risk surgical circumstances, etc.;
3) The primary surgeon has an "across the board" policy of *never* involving residents in the preoperative, operative, or postoperative care.

Several surgeons have purchased rubber stamps which state, "A resident in the required surgical specialty was not available, and the surgery was too complex for general surgery residents." Simply stamp each Medicare claim where this applies. We have reports that this system does provide satisfactory reimbursement.
OSMA Ombudsman

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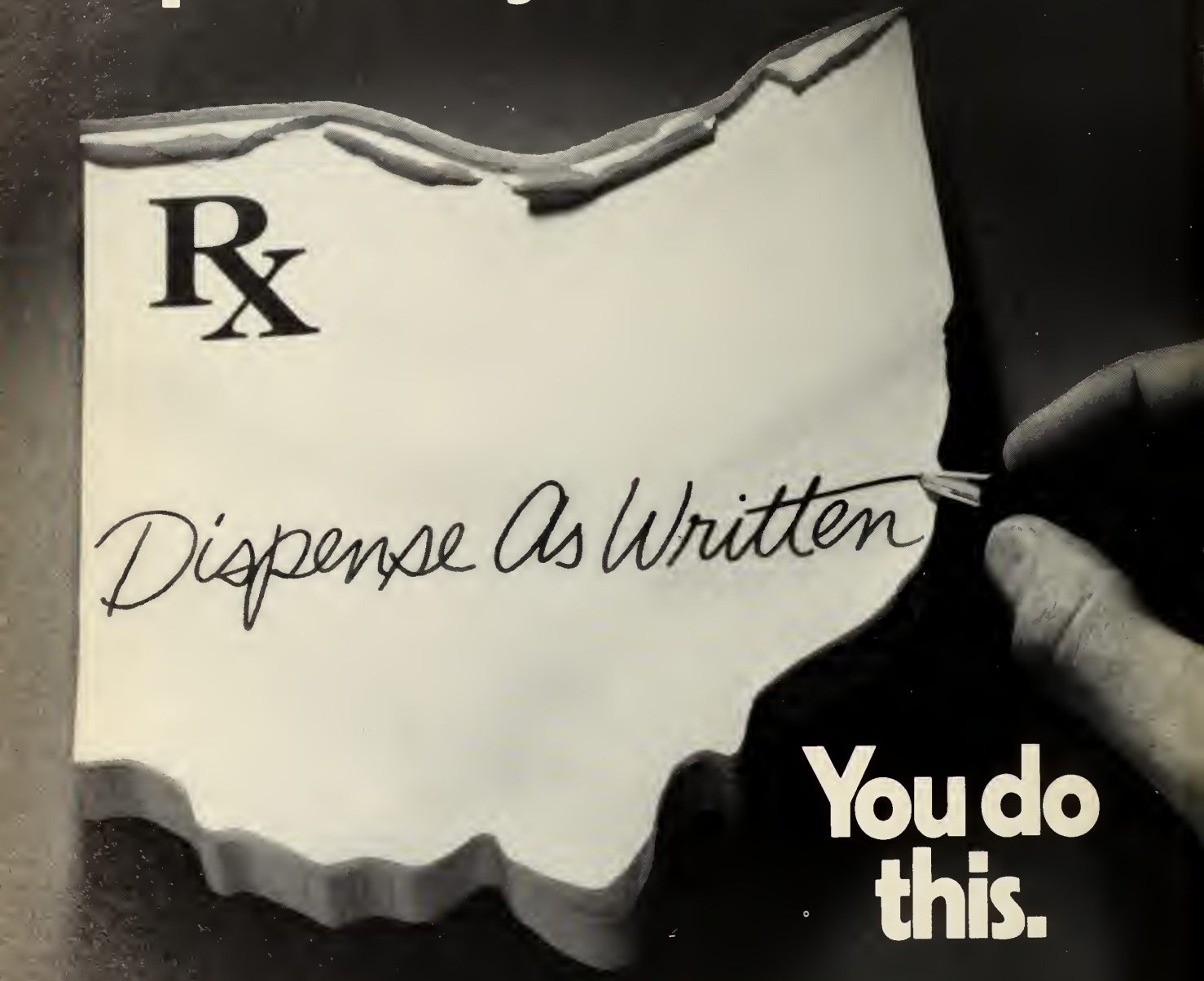
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The OSMA offers classified advertising under headings designed to serve OSMA members and the medical community. Categories generally available are: employment opportunities, equipment for sale, medical office space for sale or lease, medical practices for sale, positions wanted, services and CME seminars.

Equipment for Sale

HELP! NEEDED: Used or new medical equipment, surgical equipment, X-ray equipment, office equipment, and medical supplies of all types; lab equipment; hospital beds, etc. etc. All donations are TAX DEDUCTIBLE. Items to be sent to Haiti to be used by Lifeline Christian Mission, a Columbus, Ohio-based non-profit organization. Items will supply small 36-bed hospital/clinic to enable it to provide long-needed quality medical care to the diseased, malnourished, impoverished Haitian people. Contact Gretchen DeVoe, Lifeline phone (614) 882-8900 or write c/o PO Box 24176, Columbus, OH 43224. Thank you!

FOR SALE — State-of-the-art, brand-new, Quinton 920 Holter monitor. Price negotiable. Call (216) 394-8822 9 a.m. to 5 p.m.

PORTABLE ULTRASOUND UNIT FOR SALE: Picker Cambridge "Plus 2" portable ultrasound unit (counter-top) featuring 2-D and M-mode plus Panasonic VCR for recording. Used for 60 patients only, two years old; reasonable, condition like new. For further details contact Dr. Mark Weaver at phone (216) 455-9003 or write PO Box 35396, Canton, OH 44735.

Miscellaneous

WRIST WATCHES WANTED: Will either buy or donate to your favorite charity the value of your old doctor's wrist watch. Send watches to: Dr. Nekrosius, 5300 Far Hills Avenue, Kettering, OH 45429.

FOR PHYSICIANS: UNSECURED SIGNATURE LOANS $5,000-$60,000. No points or fees, Competitive rates, up to six years to repay, CALL TOLL FREE 800-331-4952, MidiVersal Dept. 114.

PHYSICIANS, ARE YOU CONFUSED about *Electronic Claims Processing?* "A Physician's Guide to Electronic Claim Processing" is a 25-page guide with information about health-care reimbursement and electronic claim processing. Send $18.00 (Check/Money Order) to: PO Box 79303, Lakewood, OH 44107. Allow three weeks for delivery.

Office Space

DOCTOR'S OFFICE near Eastgate Mall (Cincinnati). Available now. 2,700 sq. ft. at $10 per sq. ft. First floor, wheelchair accessible. Suitable for Family or Emergency Center. Mac or Alex Trivedi, (513) 831-8985.

OFFICE SPACE FOR LEASE
Medical office to share/part-time lease, excellent location in Worthington area. Brand new, tastefully decorated, well planned, for group or solo practice. Waiting room, administrative office, four exam rooms, large treatment room, and lab facility. Area will support practice rapidly. Call: (614) 885-2888, replies held in confidence.

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And Ready to Move In!

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Position Wanted

BOARD CERTIFIED CARDIOLOGIST (internist) Invasive-Non Invasive, Ohio licensed, wishes to join group, hospital, industry, company, etc. Reply to Box 125, c/o *OHIO Medicine,* 600 S. High St., Columbus, OH 43215.

Practice for Sale

FAMILY PRACTICE FOR SALE. Southwestern Ohio. Suburban to Metropolitan. Population 500,000. Excellent location. Easy access to six large general hospitals. Reply to PO Box 163, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215 or call (513) 866-6814 for details.

Practice for Sale

ORTHOPEDIC PRACTICE FOR SALE: Southwestern Ohio, population of 50,000. Easy access to two metropolitan areas. Sale includes orthopedic facilities (X-ray, etc.). Income may gross over $200,000. Large number of follow-up industrial cases. Box 130, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215.

WELL-ESTABLISHED DERMATOLOGY PRACTICE FOR SALE: North Central Ohio midway between Cleveland-Columbus. Good schools, cultural attractions, OSU branch. Should gross over $200,000. Office and two rental condos available. Terms negotiable. Flexible financing. Owner retiring. Send reply to PO Box 161, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215.

SOUTHEAST FLORIDA, fully-equipped, outpatient clinic. Grosses over $200,000 annually with one doctor working Mon.-Fri. 9 to 5. Act now as owner suddenly disabled. Terms. Evenings after 7 p.m. (305) 428-6226 or (305) 488-6237.

Real Estate

HILTON HEAD — Shipyard plantation, 2BR duplex. Rent direct/owner $500/wk. (513) 677-0100.

Seminars

OCCUPATIONAL MEDICINE TRAINING. Mini-Residency beginning June 6-17, 1988 and continuing October 10-14, 1988 and March 20-24, 1989. Clinical & Administrative Occupational Medicine, Epidemiology & Biostatistics, Industrial Hygiene, Toxicology, Regulations, etc. 111 AMA Cat I, AAFP prescribed, Cat 2-D AOA and Cat I participants provided. $675 per week. Sidney Lerner, MD, College of Medicine, Mail Location 182, Cincinnati, Ohio 45267-0182, (513) 872-4043.

Services

DISCOUNT HOLTER SCAN SERVICE
Starting from $35.00
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PRACTICE APPRAISAL AND BROKERAGE. Don't just close the door! Your practice may be able to be sold to a physician anxious to follow you. Our professional staff can provide you with a realistic appraisal and assistance in the transfer of your practice. Call: Physician International, Practice Appraisal and Brokerage Division, 4-0 Vermont Street, Buffalo, NY 14213, (716) 884-3700.

PROPERTY MANAGEMENT. Eliminate costly property responsibility. Substitute full-service property management. Improve earnings, increase asset value. Thirty years experience serving all Ohio and the Midwest with professional property management for apartments, condominiums, and commercial property. Detailed, current reports submitted punctually. For information or to request meeting, phone collect, J. Schwarz, President, (216) 461-4575. MANAGEMENT ONE, 1450 SOM Center Rd, Mayfield Heights, OH 44124.

Classified Advertising Rates

$1.50 per word for regular ads with bold title, $1.75 per word for ads appearing in a box. Payment for the ad must accompany advertising request. Ads must be typed. Closing date for classified ads is first day of month preceding publication.

The OSMA Journal reserves the right to refuse or delete classified ads without explanation and to refer advertisements of a commercial nature to the display advertising department, at the publisher's discretion.

Send classified ads to:

OHIO Medicine
600 South High Street
Columbus, Ohio 43215
Attention: Classified Ad Manager

Telephone orders for classified ads are not accepted.

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $2 per line.

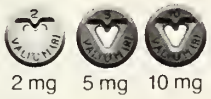
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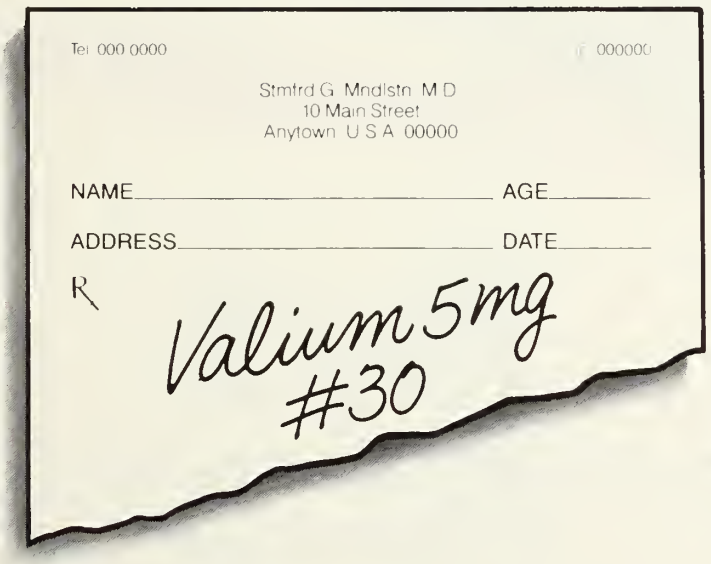
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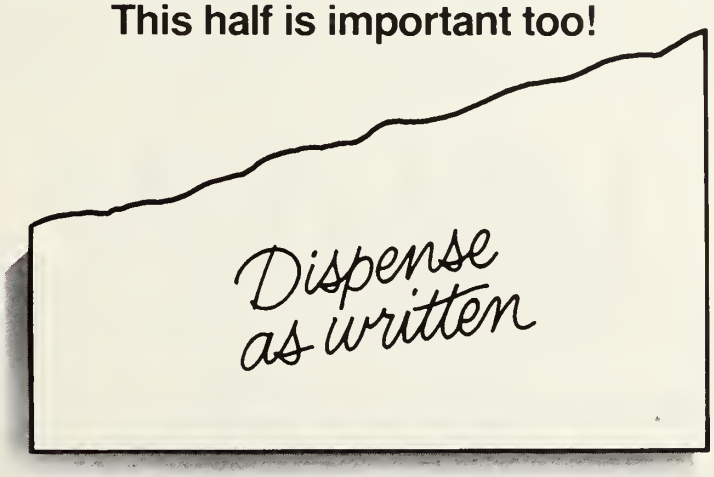
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